

**AN ANALYSIS OF THE MEDICAL PROFESSIONAL CONFLICTS
AND HEALTH CARE POLICY IN SOUTH KOREA**

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ABSTRACT

The purpose of the thesis is to explore the characteristics of the system of medical professions and its changes in terms of the conflicts existing among the medical professions in South Korea since the 1990s, in the light mainly of Abbott's theory of the professional system (Abbott, 1988). Four cases of conflict were examined and analysed: the conflict between oriental medicine and pharmacy over preparing oriental medicines; the one between western medicine and pharmacy over the separation system; the one between western medicine and oriental medicine over unification; and the one among the three medical professions over the National Health Insurance. This study used primary data from interviewing members, particularly elites, of the three medical professions, the government, the press and civic groups. The data included active and dynamic inside information about individual medical professions and conflicts.

With the conflicts, the situations of the medical professional system has changed: pharmacy kept and even strengthened its position in the professional system; oriental medicine also found opportunities to develop its professionalism and fortify its position in health care; and western medicine faced its weakening influence in the medical professional system. In addition to a change in the influence of individual medical professions, the features of the conflicts have changed. The former two open conflicts were undertaken in a strong and violent way, using strikes and street demonstrations. However, in the latter two conflicts, professions attempted academic and logical strategies to control their situations.

Through the four medical conflicts, more complex causes and situations have been uncovered in the medical professional system and health care in Korea. The conflicts have developed from professional jurisdictional ones into economic and political ones. Applying Abbott's factors to the Korean cases, the following points are outstanding: salient organisational development of individual professions; inconsistency between the influence of a dominant profession and the actual result of conflict; more dynamic and fundamental influences of political, economic, social and cultural factors; and the influence of the government's mismanagement.

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AUTHOR'S DECLARATION

This thesis is my own work. And the thesis has not been submitted for any other degree or professional qualification.

HeeKyung Choi

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CHAPTER 1. INTRODUCTION

1.1 Background of the Topic

Korea is a newly industrialised country, embracing western capitalism and the welfare system. After the severe experiences of the Korean War (1950 to 1953) and its after-effects, national effort was focused on developing the national economy. Since the 1990s, this attempt has shifted and the government has begun to place more weight on welfare policy. Health care has been central to the welfare programme with the proportion of expenditure on health being over 50% of the total social expenditure, which characterises the welfare regime in South Korea (Choi, H., 2003). However, the collision between the free market system for medical services and the government's ambitious scheme to provide social health insurance coverage for the whole population has caused social and political problems.

The three most influential medical professions in Korean health care are western medicine, oriental medicine and pharmacy. During recent decades, the number of medical professionals has rapidly increased. In addition, the Korean health care system depends upon the private sector, which provides about 90% of all medical facilities, doctors and beds. There are no barriers to opening a clinic or a pharmacy or to being employed in any medical institute after a medical professional has acquired registration by passing the qualifying examination. Under these circumstances, competition among medical professions has become increasingly intense.

Competition among medical professions has, at times, erupted into open conflict. During the last decade, there have been two open conflicts. The first one occurred between oriental medicine and pharmacy over preparing and selling herbal medicines. In 1993, pharmacists attacked the oriental doctors' monopoly in preparing herbal medicines. The provision in the Pharmaceutical Act prohibiting pharmacists from preparing oriental medicines was dropped by the Ministry of Health and Welfare. Oriental doctors protested against the government's decision and the pharmacists' challenge to their traditional jurisdiction. For five years, the two professions strongly faced each other in order to obtain or to keep that jurisdiction.

In 1997, another disruption came from strife between western physicians and pharmacists over the separation system, which referred to the division of functions between prescribing and dispensing medicines. Both professions had enjoyed the twin roles of prescription and preparation of medicines. The former endorsed each role with autonomy and pride as profession. The latter gave both professions a considerable amount

of illegal benefits from pharmaceutical companies, the so-called *margin* (6.2.2. Conflict over Economic Benefit, pp.117-121). The conflict came to the fore as the government attempted to enforce the separation system, which would eradicate the *margin* as well as divide western medicine into the two functions. There was a huge strife between western medicine and pharmacy, between western medicine and the government and among all of these.

Conflict between medical professions does not appear to be confined to those two open cases. More recently, a conflict has been emerging between western medicine and oriental medicine. Western medicine argues for unification of the two professions, while oriental medicine wants to keep its independent jurisdiction and position in health care. Based on their different fundamental purposes, the two professions have often collided with each other over practical issues, such as the medical service of *IMS (Intra-Muscular Stimulation) & Needle TENS (Transcutaneous Electrical Nerve Stimulation)*, which caused a controversy in March of 2003. In the mean time, the three medical professions also face each other to obtain a greater share in the National Health Insurance. How to allocate resources of National Health Insurance among medical professions has been another major and under-researched issue in Korean health care.

The former two open conflicts in the 1990s disturbed the whole of Korean society. Problems and controversies were evoked in social and political fields, not only in health care. The government, civic pressure groups and the press, as well as medical professions, were actively engaged in the conflicts. It was the first time in Korea that professions with such a high social and political position faced each other in public. The conflicts and their results have influenced the individual medical professions, the medical professional system and Korean health care.

1.2 Purpose of the Study

The purpose of this thesis is to explore the characteristics of the system of medical professions and its changes in terms of the conflicts existing among the medical professions in Korea since the 1990s. Four cases of conflict will be examined and analysed: the open conflict between oriental medicine and pharmacy over preparing oriental medicines; the open conflict between western medicine and pharmacy over the separation system; the conflict between western medicine and oriental medicine over unification, which is yet submerged; and the one among the three medical professions over the National Health Insurance, which is under-researched.

For every case, the background and causes of the conflict, strategies and actions of individual professions and the role of the government and civic pressure groups will be

examined. By analysing the four cases, how the medical professional system changed will be also analysed. Specifically, how the individual medical professions changed through the conflicts, how the government's policy changed with the conflicts, and how the characteristics of the medical conflicts changed will be discussed.

The study will also focus on whether or not Abbott's theory of the professional system (Abbott, 1988) can be applied to the Korean medical situation. In his work, *The System of Professions* (1988), Abbott considered professional phenomena from the perspective of a whole entity, that is, a professional system. His theory, which focuses on cases of western developed countries, is expected to explain the complex and dynamic Korean cases, which are related to diverse factors, providing a comprehensive and systematic perspective.

1.3 Significance of the Study

This thesis is primarily relevant to one of the most important and pending issues in Korea. After experiencing rapid economic development, Korea has made much of social welfare programmes. The government has particularly focused on health care policy by rapidly expanding the coverage of the National Health Insurance scheme and increasing the number of medical professionals. Because health care is directly engaged in everyday life of the entire population, the government has given its policy priority to health care programmes for their public support.

Specifically, the topic of this thesis, conflict between and among medical professions, has been one of the hottest issues and social problems in Korea in the recent decade. Because the players concerned are professionals who have a high position and strong influence in social and political fields, disorder from the conflict has been bigger than in conflicts among other groups. After the two open medical conflicts, one of the most important tasks in Korean society became arranging their relationship and policies concerned this issue.

Therefore, data from the fieldwork and the analysis of them in this study will assist government decision-makers in health care policy development, particularly on the issue of the relationships among the main medical professions.

In addition to the importance of the research topic under the present Korean situations, this study has its own significance, which is found in its object, its focus and its methodology. In recent years, the conflicts between medical professions in Korea have produced many studies. Examining existing studies on the professional conflicts in Korean health care will show how this study is characterised in those points and how it is

different from the other studies¹.

1.3.1 Existing Studies on the Medical Conflicts in Korea

Existing academic studies² on the professional conflicts in Korean health care can be examined with regard to the following three points: objects of studies, their focuses and methodology.

Firstly, with regard to objects of studies, strife between western medicine and pharmacy over the separation system, the latest conflict in Korean health care, has produced more works than any other cases have. This shows how influential the conflict is in health care and in the whole Korean society. Compared to this case, there is a smaller number of works on the first conflict between oriental medicine and pharmacy. On the relationship between western medicine and oriental medicine, there are very few works, which examined only the necessity or the possibility of co-practice or unification of the two medical professions (Lee & Byeun, 1997; Shin & Yeu, 2002), not a conflictual or real relationship between them.

There are few studies on the relationship among medical professions in the National Health Insurance, although the NHI has been one of the most popular topics in health policy in recent years³. Even among the few studies of participants in the NHI, there has been no research on the relationships among providers of health care services. The first reason is that the relationship among providers of medical services within or

¹ I mainly have searched papers in first-grade academic journals in Public Administration and Public Policy, Social Welfare, Sociology and Politics in Korea. Those are Korean Public Administration Review, Korean Association of Governmental Studies Journal, Korean Association for Policy Studies Journal, Korea Institute of Public Administration Journal, Korea Sociological Association Journal, Korea Association of Social Welfare Policy and Korean Political Science Association Journal.

² There are many non-academic publications about the recent medical conflicts in Korea. A considerable number of books have sociological backgrounds with progressive perspectives, which support reform in health care such as the separation system (Cho, 2000a, 2000b; Cho, 2003; Kim, Y. 2000; Yang, 2000). However, the number of publications from the conservative perspective, mainly written for western medicine, is small. Even they have a mild and neutral-like perspective (Park, J., 2002). Most arguments for the conservative come from self-publications, statements or notes on bulletin boards in their association. There have been publications that presented both arguments, such as Lee, J.'s (2000), but only a very few. Meanwhile, associations and subgroups in associations have made their own outputs, mainly recording chronicles and their actions during the conflicts in which they were involved, such as *document of strike* (KyungHee Oriental Medical College, 1996). However, most of them have not been published as books.

³ Main topics of studies on the National Health Insurance were the process of establishing and developing the NHI (Kim, H. 2003; Son, 1998; Choi, B., et al., 1996), unifying different social health insurance schemes (Hong, et al., 2001; Choi, B., et al., 1998), the financial difficulty of the NHI and its reforms (Shin, Y., 2000; Shin, et al., 1999; Choi, H., 1997; Choi, B., et al., 1997), setting fees for medical services in the NHI and its reform and participants and players in setting fees in the NHI (Kim, S., 1995; Park, J., 1996).

over the NHI has been strictly hidden. The other reason is that the level or allocation of the National Health Insurance fund has been important mainly for western medicine. Only in recent years, have oriental medicine and pharmacy participated in the NHI and begun to join the competition.

Secondly, focuses or main issues over the recent medical conflicts in academia of public administration⁴, social welfare and sociology are summarised as follows: the process or evaluation of the policies; the process or features of the conflicts; and the role or features of particular players such as civic pressure groups.

Most public administration and political science academic studies that deal with medical conflicts focus on the process of setting and implementing the policies and evaluating them, in addition to studying causes of any policy failure. Employing theories of policy change, some studies attempt to reveal reasons for the conflicts (Chun, 2003; Kim, J., 2002)⁵. Other studies examine the process of government compromise and intervention in the conflicts (Ahn, 2002b, 2001; Choi, 2000; Lee, J., 2001; Kim, S., 1994)⁶.

Studies in sociology or social welfare fields lighten the conflicts from the perspective of the structure of Korean health care or Korean society. Cho (2000a) emphasises the necessity for a sociological approach to the separation system. In his article, he suggests diverse conflictual situations involved in that case, such as conflict among the state, the medical capital and western medicine, between publicity of health care and the market system, between public health and professionalism and between civic groups and western medicine.

A few studies in academia of public administration and political science attempt

⁴ In Korea, the department of public administration in universities handles comprehensive issues related to the government affairs, public policies and social issues. With development of the country led by the government since the 1960s, a department of public administration has been established in almost all universities and now is one of the largest and the most popular departments in social sciences. Since the mid 1990s, with emphasis on the role of the private sector and the importance of social welfare, the department of social welfare, with some curricula describing the policy of social welfare, has become popular.

⁵ Chun (2003) analyses the policy change of the separation system by using the Advocacy Coalition Framework. Kim (Kim, J., 2002) attempts to explain why the separation system was not enforced for over 35 years, in spite of its stipulation in 1963 and why it was quickly enforced by using the policy network approach.

⁶ Ahn (2001) argues that the process of devising and implementing the separation system was a product of political interaction between participants, rather than of rational decision-making. Jo (2001) studies the influence of the separation system on interest politics by using the two-level games approach. In the conclusion, he argues that the possibility of successful negotiations between conflicting interests will decrease as democratisation continues, because democratisation reduces the autonomy of negotiators when participants from various inner groups enter into the decision making process. Ahn (2002b) uses the concept of Policy-Slippage in presenting the policy change and distortion which occurred in the negotiation process as a reason for policy failure of the separation system.

to explain the roles of the professions and other concerned players who respond and influence policies. There is a study on professionalism of western medicine, which focuses on the physicians' strike and their motivations and economic interests. Lee & Kim (2001) investigate the professionalism under the assumption that the western physicians' strike during the conflict over the separation system was an ideological strategy for economic survival. In their article, they argue that the ideology of professionalism in western medicine, which claimed that their strike was to guarantee their right to practise medicine, was merely an effective tool to obtain the public justification for winning their economic interests.

A few sociological and public administration studies emphasise the emergence and the role of civic pressure groups during the conflict (Ahn, 2002a; Cho, 2001; Park, S., 2000). Park (2000) attempts to explain why Non-Government Organisations (NGOs), instead of the government, played an important role as an arbitrator during the early stage of the conflict between oriental medicine and pharmacy, by using the concept of social capital, such as trust and cooperation. Ahn (2002a) insists that NGOs played a decisive role in the separation policy as planners and problem-solvers, rather than mediators of policy. Cho (2001) studies the NGOs' successes and failures in promoting health care reform through implementing the separation system.

There are a few works on the recent medical conflicts which focus on the medical professional system (Shin & Yeu, 2002; Cho, 2000). Although they do not use the term of 'system', the works have a consistent perspective with this thesis in that they consider the three main medical professions and their relationships together. Shin & Yeu (2002) analyse the influence of the conflict between oriental medicine and pharmacy on the separation system between prescription and preparation of medicines in oriental medicine, on unification of western medicine and oriental medicine and on the relationship between western medicine and pharmacy. They particularly argue that that conflict brought about the continuance of the dual medical system with western medicine and oriental medicine. Cho's article (2000) describes how a sectional interprofessional conflict in health care erupted into a major social cataclysm beyond the confines of health care services; how a bipartite professional monopoly system, which consists of western medicine and oriental medicine, based on the principle of professional credentialism came to be established; and how this dispute brought about a notable change in the structural power distribution between the corporate rationaliser, such as the government or civic pressure groups, and professional monopolist.

Thirdly, compared to the diverse and substantial contents of those studies, the methodology used has been simple. Except in only a few papers, most studies have

employed almost the same methodology or data sources, mainly describing the chronicles of the conflicts. Based on those chronological events, they examine what has happened and how players have acted. Then, the cause of the conflicts or of the policy failure is presented, based on a theory of public policy or politics or/and the author's own insights. The main data sources are newspapers and governmental documents. Papers in academia of Public Administration have depended on these published data. Because the conflicts are not entirely over, and the issues on the medical professions are still sensitive and controversial, there might be difficulties in researching them directly and in collecting data.

Papers in sociology tend to use other data sources as well as the published ones, such as notes on bulletin boards in the internet (Cho, 2000) and internal professional documents (Lee & Kim, 2001), although they still depend on the chronological events. Two papers using interviews to study medical conflicts were found. However, interviewing was only a minor supplementary method of collecting data. They had only one comment in the introduction stating that *the researcher interviewed a person(s) in a group concerned* (Ahn, 2002; Lee & Kim, 2001) but did not include any quotations or clues from the interview data.

Although there are a few surveys that use questionnaires to present opinions of the public or pharmacists (Song, et al., 2001; Cho et al., 2000), they seek opinions about the new scheme, the separation system, not the relationships between medical professions.

1.3.2 Characteristics of This Study

Compared with those existing works on professional conflict in Korean health care, this study has the following differences and characteristics.

Firstly, existing academic works in Korea deal mainly with the two previous and open medical conflicts as their research objects. In this study, I include a submerged, but potentially the biggest medical conflict, namely, strife between western medicine and oriental medicine. In addition, I include the newly emerging serious conflict among medical professions in the National Health Insurance. By analysing four cases of medical conflicts, that is, in which the three main medical professions have been involved, changes in characteristics of the medical system in Korea can be explored from a wide perspective. Study of the conflict between western medicine and oriental medicine and that among the three medical professions in the NHI is expected to be a fundamental work.

Secondly, the focus of this thesis is on the professional system in Korean health care. Most studies of the recent medical conflicts discuss relationships between two

professions in conflict or individual factors which influence on them. There are only a few studies of the whole medical professional system. This study supplies a systematic and in-depth perspective in understanding the medical professional system by comprehensively considering external environmental factors, as well as internal forces. Particularly, the sociological approach based on Abbott's work enlightens informal, but true, points of the medical conflicts, which the political or public policy approach of existing studies in Korea is likely to fail to catch. This study is expected to enrich the theory of professional systems by adding the case of a newly industrialised Asian country to Abbott's and others' studies, which have tended to focus on the western developed countries.

Thirdly and most importantly, I use primary data from interviews with elites in the three medical professions, the government, the press and civic groups. This might be the first study attempting to interview leaders in opposition positions simultaneously about recent sensitive issues in health care. Such data supplies active and dynamic information about decision-making processes in the individual medical professions and policy-making processes in the government, both of which were not well-known before.

Research via interviewing is expected to have another particular meaning in the Korean academia of public or social policy. In Korea, the qualitative approach to public policy has not been preferred. In the academic area of Public Administration or Public Policy, there have been few studies using interviews as the main method of research. Under the academic influence of the US, quantitative methods have dominated in those fields. Even in studies with a qualitative approach, researchers have mainly employed secondary data from government publications or chronicles. Interviewing as a research method has seldom been used, and then only in a supplementary way. Therefore, research using in-depth and elite interviews is expected to enrich the methodology of public policy, as well as supplies further and hidden information.

1.4 Overview of the Chapters

This thesis has the following composition. Chapter 1 introduces an outline of the thesis by presenting the purpose and significance of the study. By examining existing studies of the recent medical conflicts in Korea, I demonstrate the characteristics of this thesis.

Chapter 2 presents a general picture of the medical professional system in Korea. Development of the three main medical professions, their recent situations and open conflicts among them and the importance of the National Health Insurance for them are shown as backgrounds of the study topic.

Chapter 3 presents the theoretical approach of this study. The theoretical

background and framework are set based mainly on Abbott's *The System of Professions* (1988) and on other related studies.

Chapter 4 presents research methodology of the thesis. Research methodology is emphasised by specifically describing what was done before and during the fieldwork, because a qualitative approach with elite and in-depth interviews would have a particular meaning for the public or governmental field in Korea.

Chapter 5, 6, 7 and 8 present the individual cases of medical conflict in Korea. Chapter 5 considers the first open conflict in Korean health care, which occurred between oriental medicine and pharmacy over the issue of preparing herbal medicines. It presents how and why the two professions became conflicted in public and what factors influenced it.

Chapter 6 considers the second open, and the biggest, conflict in the Korean medical system, which occurred between western medicine and pharmacy over the separation system. It implies that this conflict would become related to the first case, yet the case also shows how different it was from the first case.

Chapter 7 considers a submerged conflict between western medicine and oriental medicine. There are two issues in the conflict: one is over unification of the two professions and another is over the treatment of *IMS & Needle TENS*, which could potentially develop into the former issue. Conflict between these two professions is not as open as the previous two, but is expected to supply information needed for understanding the entire medical professional system in Korea by suggesting another professional conflict, which is yet being openly addressed.

Chapter 8 is about the conflict among the three main medical professions in the National Health Insurance (NHI) to obtain a bigger share of the NHI fund. This chapter presents how these professions, which have already experienced open conflict once or twice, relate with each other under different situations and conditions.

Chapter 9, the concluding chapter, discusses the Korean medical professional system and its change in terms of the conflicts based on Abbot's study and other theoretical backgrounds. This chapter also presents implications of the study and further research opportunities in the future.

CHAPTER 2. INTRODUCTION TO KOREAN HEALTH CARE

In this chapter, general situations within Korean health care are introduced as the background for the thesis. During recent decades, Korean health care has experienced remarkable changes. The most important phenomena have been the rapid increase in medical professionals and the changes and financial difficulties in the National Health Insurance. All these have been related to the recent conflicts between medical professions.

This chapter starts with a brief introduction to the nation of Korea. A modern history of Korea is expected to help in understanding the development process and the general situation of Korean health care.

Three main medical professions, which are the main players in the recent medical conflicts and in this thesis, are then introduced. In this section, I examine how the individual professions were imported or created and developed, what professional knowledge and philosophy they possessed, and what their organisational and political features they exhibited. For every profession, I attempt to supply sociological and recent information, which is related to points in my analysis and consistent with the sociological perspective of this thesis.

Those circumstances of the medical professional system, which are more directly related to the recent conflicts, are suggested. The data show how rapidly the three main medical professions have grown. Also explained is how and why their roles and functions have been unclear. Then, the recent two open conflicts are briefly presented.

Finally, the history of the National Health Insurance, its payment system for medical professions and its recent financial difficulties are suggested to explain recent situations of the medical professional system and the medical conflicts presented in this thesis. The payment system and financial difficulties of the NHI supply important information for understanding the background of the second conflict, which occurred between western medicine and pharmacy over the separation system. The third case in the thesis, the conflict between western medicine and oriental medicine, also includes an issue with the NHI.

2.1 Introduction to the Nation of Korea

For over 4,000 years, Korea developed its own traditional culture with a homogeneous race and distinctive language, while coping or cooperating with China and Japan. Its entrance to western and world history, however, was not easy. In 1876, Korea was forced to open its door to Japan and to western countries, resulting in Korean subordination to

Japanese Imperialism. In 1910, Korea lost its sovereignty and remained under Japanese rule until 1945.

After the 1945 Liberation, Korea became a battlefield for the Cold War between the USSR and the US: Korea was split into the North, which was sponsored by the USSR, and the South, which was supported by the US. In 1948, South Korea proclaimed its foundation as the Republic of Korea and began a western-style democratic regime. However, the Korean War (1950 to 1953) burned up all the resources, facilities and systems in the country. An armistice was signed in 1953, splitting the Korean Peninsula along a demilitarised zone at about the 38th parallel. After the Korean War, South Korea came under autocratic rule. In 1960, a bloody student demonstration rose and overturned the first government, which had been established in 1948.

In 1961, Major General Park Jung-Hee captured power with a military coup and kept his autocratic rule until 1979, when he was assassinated. Under his rule, Korea accomplished rapid economic development with a series of Five-year Economic Development Plans and a social health insurance scheme was introduced.

In 1992, after experiencing another military coup and another two presidents' rule from the military field for 13 years, Koreans elected the first civilian president Kim Young-Sam. During his administration, there occurred the first external conflict in health care between oriental medicine and pharmacy. In December of 1996, Korea joined the OECD. However, the Asian financial crisis of 1997-1999 seriously damaged the Korean economy.

During that economic crisis, Kim Dae-Jung, veteran opposition leader, won the Korean Presidential Election. Led by a strong reform in the economic field and following the recommendation of the IMF and high consumer spending and exports, growth in 2002 was an impressive 6.2%. However, it also left social suffering and mass forced retirements. The government of President Kim Dae-Jung reformed the social welfare system, particularly health care, which caused disorders that included *the so-called Medical Disturbance*, as well as development. In 2003, Roh Mu-Hyun, another liberal reformist, won the Presidential Election of Korea, expecting to continue the reformist line.

2.2 Three Main Medical Professions

In Korean health care, the three most influential medical professions are western medicine, oriental medicine and pharmacy. Each of the three main medical professions, which became involved in the recent medical conflicts, developed with different histories and different characteristics. Historical backgrounds, professional knowledge and organisational features will be separately examined for the three professions.

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2.2.1 Western Medicine

2.2.1.1 History

Western medicine in Korea has dramatically developed since its introduction. It arrived and developed through three routes (Kim and Nahm, 1999): in 1885 as a royal hospital by American and European missions; in 1899 as a government organisation under Japanese political pressure, which was a process of colonisation; and in 1877 as a Japanese hospital for the Japanese residents of Korea. After the Gab-O Reform to modernise the country, executed in 1894 under pressure from the Japanese government, the law of western medicine replaced the law of Korean traditional medicine.

Experiencing US military administration after the 1945 Liberation and the Korean War during 1950 to 1953, the government then introduced medical knowledge and technology, medical systems and medical education from the US. Most public hospitals and missionary hospitals suffered from the lack of sufficient medical professionals, outworn equipment and financial difficulty.

Private clinics and hospitals, which had first appeared under the Japanese regime, started to grow in the 1960s. The facts that university hospitals were established from 1945 and the speciality system was introduced in 1958 provided favourable circumstances for developing private hospitals. Private hospitals have superseded public and missionary ones since the 1970s, primarily because of the explosion of medical demand, which accompanied rapid economic growth. The government has increased the number of medical colleges and their quota since the 1970s, in accordance with the increase in medical demand. The introduction of the national health insurance scheme in 1977 and its extension to the whole population in 1989 required more medical professionals, which then led to a thriving growth of private clinics and hospitals.

Public and missionary hospitals also attempted to find a way for survival. National university hospitals changed their forms into public corporations; and provincial and municipal ones also changed into local corporations, which were part of the government's privatisation policy strategy. Most missions from foreign countries transferred their ownership of hospitals to Koreans in the 1970s. Although the number of missionary hospitals has hardly increased since the 1960s, they have settled down as good-quality general hospitals.

Since the mid-1980s, the number of western physicians, and then of clinics and hospitals, has dramatically increased. Under the competitive market system of medical services and inauguration of the National Health Insurance for the whole population in 1989, some medical institutes, mainly small clinics in suburban and local areas, started to suffer financial difficulties. The external conflict with pharmacists and the government

over the separation system disturbed the whole of western medicine.

2.2.1.2 Professional Knowledge

When it comes to professional knowledge and technology, western physicians have enjoyed superior position and more privilege than other medical professions. The scientific and rational methods for diagnosis and treatment have been a strong point of western medicine. In accordance with the westernisation of life and economic development, people have preferred western medical institutes and western physicians who have continually introduced updated knowledge and skills to meet those demands. Reports on competitive installation of highly expensive equipment in hospitals, along with a large demand for new treatments or operations, show professionals' and patients' enthusiasm for high technology and advanced knowledge (Weekly Chosun, 2001; Lasik4you, 2000)

2.2.1.3 Organisational Features

To be a western physician, one should graduate from a medical school with a six-year course and pass the national examination for the licence. Nowadays, 98% of young western physicians enter the course to be a specialist (Beck & Hwang, 1997: 29), which requires one-year internship, four-year residency and an examination.

Western physicians have several formal, informal, academic, regional and friendly societies. The most important two groups in western medicine are the Korean Medical Association and the Korean Hospital Association. The Korean Medical Association (KMA), which was established in 1908, is the most representative and influential group for all 75,000 physicians. The Korean Hospital Association (KHA), which was established in 1959, consists of 954 public and private hospitals. The main functions of the KHA are to examine the financial situation of hospitals, to deal with labour disputes in hospitals and to arrange the quota of interns and residents. The KHA could influence western medicine and health care policy by representing and mobilising huge capital, while the KMA has strong power by representing and mobilising individual western physicians.

Western medicine has a bureaucratic feature in its organisation. Western physicians follow and adapt themselves to a hierarchy from new medical student to specialist for about 15 years, including military service. The speciality system of western physicians reinforces this strict bureaucratic system and culture. Since most general practitioners take a training course in hospitals during their five years of becoming a

specialist, the relationship and order between seniors and juniors are strict. However, once opening their own clinics, individual physicians can enjoy autonomy. The bureaucratic feature of western medicine appeared to be strong during its conflict with pharmacists, with trainee doctors playing the most active and decisive role in the conflict. They mobilised medical students and organised physicians to face the government and pharmacists.

The political influence of western medicine is known to be strong but it is not easy to identify. Membership in politics may be one way of measuring this. With reference to the news at the last Assembly Election in 2000, western medicine supported the candidates from their association because of the existing conflict with pharmacists. Four doctors and two dentists won that Election, which was the best outcome among the medical professions, as compared with two pharmacists and no oriental doctors (HanuiHyupSinMun, 2000).

2.2.2 Oriental Medicine

2.2.2.1 History

While the history of oriental medicine is long, tracing back to the Iron Age, it had the bitter experience of being suppressed for 50 years under Japanese Governance⁷. There are many references to the fact that Korean ancestors had used their own traditional medicine before the period of Three States at the beginning of the Iron Age. Chinese traditional medical science, ‘Yin and Yang’ and ‘Five Elements Theory’, was imported to the Unified Shilla State in A.D. 692.

In the Korye Dynasty established in 935, Buddhism, the then national religion, was closely related to traditional medicine. The government equipped a bureau and a school of traditional medicine. From this time, efforts to set up their own original medical theory and system had commenced, differentiated from the Chinese one. The concept of ‘Hanuihak (traditional medicines in Korean)’, which originated from this time, means that diseases occurring in our country will be cured by oriental herbal medicines produced in our country. Efforts to establish a whole system of traditional medicine by taking the national customs and constitutions of the Korean people into consideration achieved brilliant results in the Chosun State. Some examples are Four-Type Constitutional Medicine, Sa-Am's acupuncture and an encyclopaedia of oriental medicine, *Donguibogam*, written by Hur Joon in 1713.

⁷ The following history is a summary from the websites of the Association of Korean Oriental Medicine and the OKmediTV, and a document of MOHW, Traditional Korean Medicine Services (MOHW, 2000).

However, in 1898, the law of western medicine was enacted to replace it. This prompted the decline of Korean traditional medicine and the rise of western medicine. Until the 1945 Liberation, the Japanese government abolished oriental medicine as part of the Liquidation Policy, which was meant to eradicate all Korean traditional culture.

In 1945, the Association of Chosun Oriental Medicine, the former institution of the present Association of Korean Oriental Medicine, was organised. In 1947, a college of oriental medicine with a 4-year course was established. Once the Medical Service Act was enacted in 1951 and took effect in 1952, the Minister of Health and Social Affairs officially approved the Association of Korean Oriental Medicine, which meant Korean health care had two medicines, western and oriental. In October 1961, the military government passed law, which did not authorise oriental medicine in health care. Five months later, following opposition from oriental doctors and medical students, the government re-authorised oriental medicine. In 1964, oriental medical colleges changed their curricular systems to a 6-year course.

In recent years, due to concern about the oversupply of western physicians, oriental medical colleges have emerged as one of the most popular choices among the best high school students.

2.2.2.2 Professional Knowledge

Oriental medicine has developed with its philosophy that the human body is a miniature universe. The energy that controls nature, in addition to 'Yin and Yang', that is, the doctrine of the five natural elements of the positive and negative, is applied to heal diseases in oriental medicine. Oriental doctors believe that oriental medicine treats the fundamentals of disease, while western medicine treats only the external phenomena or results (Kim, T., 1993). This perspective makes oriental doctors reject applying western medicine to oriental medicine. One of the most important features of oriental medicine is integration of all processes of diagnosis and treatment, considering whole factors related to diseases.

Based on the concept of holistic practice, oriental doctors are sceptical of oriental pharmacy. This newly introduced profession came from the concept of dividing medicine into the two functioning of prescribing and preparing medicines, as pharmacy in western medicine. Oriental pharmacy resulted from the conflict between oriental medicine and pharmacy in the mid 1990s (5.2.1.2 Oriental Pharmacy, pp.79-81).

Since the late 1990s, the introduction of a speciality system that would divide oriental medicine into specific departments has emerged as another issue in oriental medicine. According to the government's master plan for the development of oriental

medicine, in 2002, the first Qualifying Examination for Oriental Medical Specialties came into force⁸. However, enforcing the speciality system has provoked serious controversies within oriental medicine (Dongguk University Press, 2002; OKOMHospital, 2002a, 2002b; Dental News, 2001). First of all, most oriental doctors have been sceptical of the speciality system, because they believe that the speciality system originated in western medicine, in which doctors practise on only a certain part of a patient, and therefore, it does not apply to oriental medicine, which pursues holistic practice and treatment.

The speciality system in oriental medicine also has a practical problem. According to a leader of oriental medicine:

It is difficult for a trainee doctor in a hospital to take proper training. 90% of inpatients and 80% of outpatients in an oriental hospital are palsied patients. For example, a trainee doctor in paediatrics, who is expected to be a specialist of paediatrics, would finish his course after mostly taking care of palsied patients (*OrientalDoctor4*).

Oriental doctors' concern about the speciality system erupted into an open conflict within oriental medicine, when professors in oriental medical colleges were authorised to obtain qualification to take the Qualifying Examination for Oriental Medical Specialties. Oriental doctors in clinics, who make up over 80% of oriental medical doctors, have seriously opposed it: oriental doctors in clinics are required to take a four-year training course to take the Qualifying Examination, while professors are not. They believe that the government granted a privilege only to professors. They argue that those in clinics are more, not less, than professors in oriental medical colleges (*OrientalDoctor4*). Now they press the government to grant all of them qualification to take the Qualifying Examination for Oriental Medical Specialties (OKmediTV, 2002).

Behind the controversies about oriental pharmacy and the speciality system, there has been a fundamental issue: scientisation of oriental medicine. Weak scientisation has been the Achilles' heel of oriental medicine. Pharmacists and western physicians have disparaged oriental medicine due to its lack of scientisation and rationality. They do not trust holistic treatment in oriental medicine, which is considered by western medicine as only "superstition (p.99; pp.186-187)".

During the last decade, colleges and younger doctors in oriental medicine have

⁸ To take the Examination for being a specialist, an oriental doctor, who graduated from 6-year oriental medical college and passed the Qualifying Examination for Oriental Medical Licence, has to finish a one-year internship and a three-year residentsip at a designated hospital (MOHW, 2000). At the first Qualifying Examination, the ratio of success was 95%, among 260 applicants.

spurred themselves to supplement this shortage and develop high technology for diagnosis and treatment. Academic groups for computerisation of clinical information in every college are actively at work⁹. However, as the result of the analysis in this study showed, many oriental doctors are still sceptical of the movement toward scientisation and modernisation of oriental medicine (pp.188-191).

2.2.2.3 Organisational Features

To be an oriental doctor, one should graduate from an oriental medical college with a six-year course and pass the national examination for licensure. The newly-introduced speciality system requires a one-year internship, a three-year residency and the examination to be a specialist.

At present, there are about 10,000 members and 16 local branches in the Association of Korean Oriental Medicine. Oriental medical institutes are divided into clinics and hospitals. As shown in Table 2-1, the number of small-scale clinics is far greater than that of large-scale hospitals.

Table 2-1 Status of Oriental Doctors and Oriental Medical Institutes

	Total	Oriental Hospitals	Oriental Clinics
Number of Oriental Medical Institutes (% of all oriental medical institutes)	7,412 (100 %)	136 (18 %)	7,276 (82 %)
% of Oriental Doctors in Hospitals or Clinics	100%	13 %	87 %

Source: Ministry of Health and Welfare (2000)

A small clinic managed mainly by one or two doctor(s) is typical of an oriental medical institute and consistent with the original property of oriental medicine. Because of its traditional silent and inconspicuous characteristics, oriental medicine was able to fit in the grassroots and maintain its slender existence even under pressure from Japanese rule (YoonClinic, 2002).

However, as large capital has been introduced to oriental medicine and well-equipped hospitals have recently appeared, the characteristics of oriental medicine have begun to change. Oriental medical hospitals have attempted the scientisation and modernisation of traditional medicine. While the Association of Korean Oriental Medicine (AKOM) is still inclined to be on the side of small clinics, the majority of oriental medical institutes, the Korean Oriental Medicine Hospital Association (KOMHA)

⁹ Attempts for scientisation of oriental medicine became more active with the establishment of new national institutions, such as the Korea Institute of Oriental Medicine (KIOM) and the Korean Oriental Medical Service Team Abroad (KOMSTA).

mainly support large-scale hospitals.

These two organisations have different perspectives on the recent issues. Firstly, AKOM takes a sceptical view of the new system that separates prescribing and preparing oriental medicines. KOMHA, however, is comparatively positive to the separation system, since hospitals operate on the basis of division of labour by specialties and functions. Secondly, while KOMHA is more positive to the speciality system and co-practice with western medicine, AKOM is not: attempts at scientisation of oriental medicine in oriental medical hospitals and their system are compatible with co-practice and the speciality system.

In the meantime, it is rare for oriental doctors to go in for politics. None of the present assemblymen are oriental doctors, and three members are reported to have relatives in oriental medicine. Instead, taking advantage of their tradition and of Koreans' respect for national heritage, oriental doctors obtain strong support from the public.

2.2.3 Pharmacy

2.2.3.1 History

With the beginning of the 20th century, western pharmaceutical theory and drugs came into Korea with other western products and culture. In 1912, the first pharmacists were created. Under Japanese governance, pharmaceutical educational institutions were established (Shim, 2002). Until the 1945 Liberation, pharmacists functioned mainly as researchers rather than ones who prepared or sold medicines.

Since the 1950s, the number of pharmacists and their influence have increased. There are two main reasons for pharmaceutical growth. First, educational policy led to an increase in the number of pharmacists. Because of the Educational Act amendment, eleven pharmaceutical colleges were established during 1952 to 1956. Many colleges were promoted to universities, meeting the requirement of opening at least one college of science and engineering. A pharmaceutical college was preferred by universities to colleges of engineering, agricultural colleges and medical colleges, since the requirement of equipment for approval was quite loose (Kim, J., 1996). Owing to pharmacists' exclusive right to open a chemist's shop with the enactment of the Pharmaceutical Act in 1953, this medical field was considered one of the best professions, attracting many competent high school students.

Second, there is an argument that economic policy and western capital led to the explosion of pharmacists (Hong, K., 2002). During the 1950s after the Korean War, eight pharmaceutical companies were established as a part of the aid project by the US. This new industry played a leading role in economic development, and Korea rose as a new

important drug market for the US. To increase the demand for drugs and to expand the market, many pharmacists were necessary.

It is true that pharmacists had replaced doctors by seeing patients and then prescribing and preparing medicines for them. Until the 1980s, patients had had difficulty in seeing a doctor. Doctors and medical facilities had been insufficient, and medical services had been expensive. People had resorted to pharmacies instead of hospitals or clinics, and pharmacists had functioned as primary care providers by prescribing, as well as preparing, medicines. Since the 1980s, those circumstances changed through a dramatic growth in the number of western physicians, due to the increase in medical colleges. Until 1989, the national health insurance scheme had rapidly expanded to include the entire population. Patients started to choose clinics or hospitals, instead of pharmacies, and paid doctors a low fee. At the same time, the number of pharmacists continued to increase. These situations have led pharmacists to professional and financial difficulties.

2.2.3.2 Professional Knowledge

Compared with western physicians and oriental doctors, pharmacists suffer from serious difficulties in their professional identity and professional knowledge. Nevertheless, in recent years, pharmacists have shown swift and brilliant achievements in extending their scope of knowledge, and their jurisdiction and position. The process of obtaining the right to prepare herbal medicines can be an example. First, arguing that ‘herbal medicines, after all, belong to medicines’, the pharmaceutical college opened oriental herb classes. Second, pharmacists argued that they had rights to take the Examination for Licences to prepare herbal medicines, giving the evidence that they already had herb lessons in colleges. Third, after the government accepted their argument and suggested the required number of credits related to the subject of herbal medicines, pharmaceutical colleges took steps to meet the required number of units for qualification in the examination by creating a special summer session (Yonhap News, 2000).

Pharmacists also participated in the project of data-banking all the information of *Donguibogam*, a historical encyclopaedia of oriental medicine in Chosun (Chosun Newspaper, 1996). Because the encyclopaedia had been the very uncompromising pride of oriental doctors, this achievement appeared to be another accomplishment for pharmacists. The most active effort to enhance their level of knowledge in recent years has been an attempt to change the present 4-year training system into a 6-year course and to introduce the US concept of ‘clinical pharmacist’.

2.2.3.3 Organisational Features

To be a pharmacist, one should graduate from a pharmaceutical college with a four-year course and pass the national examination for licensure.

The Korean Pharmaceutical Association, which was established in 1928, has 16 local branches, 5 overseas branches and 227 chapters. The structure of pharmaceutical employment is shown in Table 2-2.

Table 2-2 Pharmacists on the Job (31 Dec. 2000)

Pharmacist		Male	Female	SUM
Pharmacy	Owner	8,540 (75%)	7,782 (61.3%)	16,322 (67.6%)
	Employee	450 (4%)	565 (4.5%)	1,015 (4.2%)
	Total	8,990 (79%)	8,347 (65.8%)	17,337 (71.8%)
Hospital		102 (0.9%)	1,296 (10.2%)	1,398 (5.8%)
Others		2,350 (20.5%)	3,043 (24%)	5,393 (22.4%)
SUM		11,442 (100%)	12,686 (100%)	24,128 (100%)

Source: The Korean Pharmaceutical Association

(http://www.kpanet.or.kr/kpa/01kpa_info/01public_kpa_info_frame1.html)

72% of total pharmacists work in pharmacies and 68% of them own and manage their own pharmacy. The number of female pharmacists surpasses that of males. For Korean women, a pharmacist has been considered one of the best professional occupations. In Korean society, unlike in western developed countries, women have had only a few chances to obtain a professional job, and pharmacists and teachers were the best professional jobs for them, being considered an autonomous and stable occupation with considerable income¹⁰.

10% of female pharmacists work in hospitals, while only 1% of male pharmacists do. In hospitals, there are bureaucratic features and distinctions among staff. In that situation, pharmacists would be regarded as a subordinate group of western physicians. The low rate of male pharmacists in hospitals implies that those circumstances would be even less comfortable for them than for female pharmacists.

Active lobbying from pharmacy is well known to government officials and the press, as well as other medical professions¹¹. While there have been a few government officials from other medical professions, a considerable number of government officials came from pharmacy¹². They are known to function as backups for pharmacy. Among the

¹⁰ According to the latest research, female pharmacists are the most desirable brides (SunOo, 2003).

¹¹ One of the biggest scandals was supplying black money to the former President's son, who had influence in the middle 1990s (DongA.Com, 2000a).

¹² According to data in December 1992, 40 government officials came from pharmacy with

present Assemblymen, two members are former pharmacists, a smaller number than that of western physicians, which is six, including two dentists. The interesting thing is that three Assemblymen's wives are pharmacists and that there are some members who have relatives as pharmacists (HanuiHyupSinMun, 2000). This would be consistent with the argument that pharmacy has diverse and influential informal, personal networks.

2.3 Growth of Medical Personnel and Recent Medical Conflict

2.3.1 Providers of Health Care Services in Korea

Western physicians, dentists, oriental doctors, midwives and nurses are licensed by the Ministry of Health and Welfare and prescribed as medical persons by the Medical Service Act¹³ (Medical Service Act, Article 2). Although not included in the category of medical persons by the Medical Service Act, pharmacists have played an important role in health care, functioning in high positions with a strong influence. The growth and composition of medical persons and pharmacists are shown in Table 2-3.

Table 2-3 Growth of Medical Personnel (unit: person, %)

Year	Total	Western Physicians	Oriental Doctors	Pharmacists	Dentist	Nurses	Midwives
1975	69,427	16,800	2,788	19,750	2,595	23,721	3,773
1980	99,094	22,564	3,015	24,366	3,620	40,696	4,833
1985	134,642	29,596	3,789	29,866	5,436	59,708	6,247
1990	192,944	42,554	5,792	37,118	9,619	90,218	7,643
1995	254,377	57,188	8,714	43,269	13,681	123,173	8,352
2000	326,975	72,503	12,108	50,623	18,039	164,974	8,728
Composition Rate (unit: %)							
Year	Total	Western Physicians	Oriental Doctors	Pharmacists	Dentists	Nurses	Midwives
1975	100	24.2	4.0	28.4	3.7	34.2	5.4
1980	100	22.8	3.0	24.6	3.7	41.1	4.9
1985	100	22.0	2.8	22.2	4.0	44.3	4.6
1990	100	22.1	3.0	19.2	5.0	46.8	4.0
1995	100	22.5	3.4	17.0	5.4	48.4	3.3
2000	100	22.2	3.7	15.5	5.5	50.5	2.7

recommendations by the Korean Pharmaceutical Association, while none came from oriental medicine (Kim, J., 1994: 65; Seoul YMCA, 1994: 435).

¹³ In Addition to these official medical persons, there are quasi-medical persons prescribed by the Medical Service Act: bone settlers (30 persons in 2000), acupuncturists (48), moxibustionists (6), massagers (2,721) and nurse's aides (239,740 in 1999). There are other personnel in health care prescribed by the Health and Medical Service Technology Promotion Act: medical technicians (94,467 persons in 2000), medical records officers (7,644) and opticians (20,220) (MOHW, 2003).

(Table 2-3 Growth of Medical Personnel: Continued)

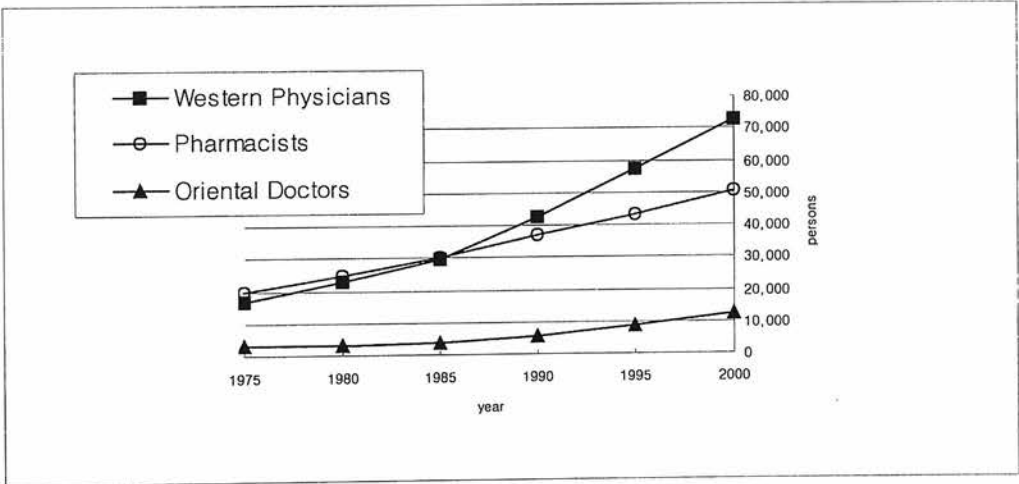
5-yearly Growth Rate (unit: %)							
Year	Total	Western Physicians	Oriental Doctors	Pharmacists	Dentists	Nurses	Midwives
MEAN	36.5	34.1	35.2	20.8	48.1	48.0	18.7
1975~1980	42.7	34.3	8.1	23.4	39.5	71.6	28.1
1980~1985	35.9	31.2	25.7	22.6	50.2	46.7	29.3
1985~1990	43.3	43.8	52.9	24.3	76.9	51.1	22.3
1990~1995	31.8	34.3	50.4	16.6	42.2	36.5	9.3
1995~2000	28.5	26.8	38.9	17.0	31.9	33.9	4.5

Source: MOHW, Health Resources Division (2003)

In recent decades, individual health care provider groups have experienced a rapid increase in membership, while midwifery numbers have increased more slowly. The number of nurses has continuously increased and forms the largest portion of health care personnel. The most outstanding phenomenon in the composition of the health care personnel is the rapid decrease in the proportion of pharmacists. Nevertheless, the proportion of pharmacists is still considerable at 15.5%¹⁴, which would imply their strong position and influence in health care, particularly until the early 1980s. The number of western physicians and oriental doctors has increased about 35% every 5 years, leading to competition and tension among providers of health care services.

The following Figure 2-1 shows the growth of western physicians, oriental doctors and pharmacists, who have been the most important and influential medical professionals in Korean health care.

Figure 2-1 Growth of the Main Medical Professions (1975 to 2000)



Graphed based on Table 2-3

¹⁴ The proportion of pharmacists to physicians, 0.7, is higher than that in western developed countries.

As shown in Figure 2-1 based on Table 2-3, after 1985, the number of western physicians surpassed that of pharmacists. During the 1980s to 1990s, the government substantially increased the number of medical schools. There were 19 medical schools in 1980, 31 in 1990 (KMA, 1997) and 41 in 2003¹⁵. Western physicians also increased rapidly. A few recent studies pointed out that western physicians could be oversupplied in the nearer future (Beck & Hwang, 1997). However, during the 1980s to 1990s, the government accepted the research indicating that Korean health care would require more western physicians (Song, et al., 1994).

The increase in medical professionals led to the increase in medical institutes. With over 90% of medical services provided by the private sector and all pharmacies owned and operated by individual pharmacists, the rapid increase in medical professionals and institutes made competition keen among the three medical professions in the health care market.

Medical institutions are categorised into general hospitals, hospitals and clinics by their scale, the number of beds and their specialities (Medical Service Act, Article 3). General hospitals are medical institutes in which western physicians give medical treatment at facilities capable of hospitalising more than 100 inpatients. Their specialised departments for medical treatment include sections such as internal, surgical, paediatric, obstetrics, X-ray, anaesthetic, pathological, psychiatric and dental, with necessary medical specialists in each section. Hospitals or oriental medical hospitals are medical institutes in which western physicians or oriental doctors give medical treatment at facilities equipped with more than 30 inpatient beds. Medical clinics or oriental medical clinics are medical institutes in which western physicians or oriental doctors give medical treatment at facilities designed for medical examination and treatment.

Table 2-4 shows the growth of the number in medical institutes since 1975. As shown in Table 2-4 and Figure 2-2, western medical institutes have increased faster than any other facilities. For the last five years, the number of western hospitals has increased 46%, which suggests a preference by patients for large-scale facilities. Western and oriental clinics have been placed in the most important positions of all medical institutes, continually showing a considerable growth rate. Although their number is still small, oriental medical hospitals have expanded the most rapidly. In recent years, the number of

¹⁵ Since the 1990s, the Ministry of Health and Welfare has attempted to control the increase of western physicians, but the Ministry of Education has continued authorising new medical schools and increasing the quota of medical students. In the meantime, a scandal, in which a few important political figures were bribed by a few universities that wanted to establish a medical school, was revealed and the persons concerned incurred a penalty (KMA, 2000: 372-373).

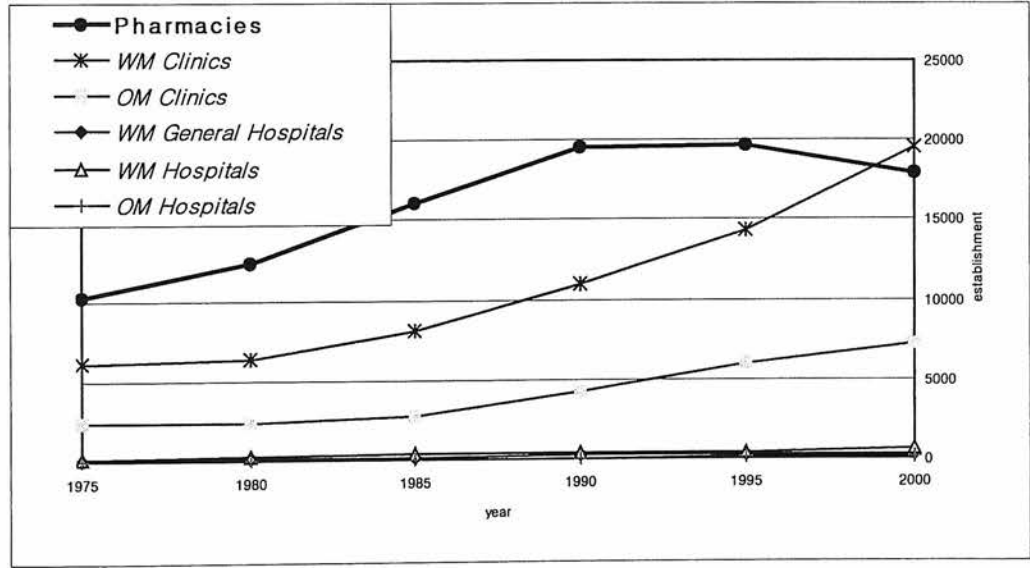
pharmacies has decreased, which implies that their role has declined. National Health Insurance for the whole population in 1989 influenced patients to prefer clinics or hospitals to pharmacies, bringing financial difficulties to pharmacies.

Table 2-4 Growth of Medical Institutes (unit: establishment)

Hospital	Year	1975	1980	1985	1990	1995	2000	5-yearly Average Growth Rate
General Hospital		37	82	183	228	266	285	
Growth Rate			(121.6%)	(123.2%)	(24.6%)	(16.7%)	(7.1%)	58.6%
(Western) Medical Hospital		133	240	317	328	398	581	
Growth Rate			(80.5%)	(32.1%)	(3.5%)	(21.3%)	(46.0%)	36.7%
(Western) Medical Clinic		6,087	6,344	8,069	10,935	14,343	19,472	
Growth Rate			(4.2%)	(27.2%)	(35.5%)	(31.2%)	(35.8%)	26.8%
Oriental Medical Hospital		5	11	17	33	69	136	
Growth Rate			(120.0%)	(54.5%)	(94.1%)	(109.1%)	(97.1%)	95.0%
Oriental Medical Clinic		2,377	2,317	2,774	4,261	5,928	7,276	
Growth Rate			(-2.5%)	(19.7%)	(53.6%)	(39.1%)	(22.7%)	26.5%
Pharmacy		10,197	12,337	16,097	19,523	19,624	17,968	
Growth Rate			(21.0%)	(30.5%)	(21.3%)	(0.5%)	(-8.4%)	13.0%

Source: Ministry of Health and Welfare, Health Resources Policy Division (2001)

Figure 2-2 Growth of Medical Institutes (1975 to 2000)



Graphed based on Table 2-4

2.3.2 Unclear Division of Roles among Medical Professions and Institutes

In addition to the rapid increase in medical professionals and medical institutes, the fact that there has not been clear division of roles among medical professionals, medical professions and medical institutes has made the competition among all of them even greater.

Firstly, there has not been a clear distinction of roles between specialists and general practitioners. There *are* official western medicine specialists, who passed the examination for specialists after an additional 5-year training course. Including the prospective specialists in the training course, over 90% of western physicians are specialists in Korean health care¹⁶. However, about 50% of specialists¹⁷, who open and manage their own clinics, function as general practitioners in practice. Particularly, 100% of preventive medical clinics, 97% of anaesthesia clinics, 85% of chest surgery clinics, 57% of tuberculosis clinics and 31% of general surgery clinics officially stand for general practice, instead of specifying their speciality (KMA, 2000: 325).

In the meantime, almost all official general practitioners in western medicine, who have the licence of a physician, are on the training course to be specialists in hospitals under the strict control of specialists. Legally and officially, all trainee doctors are general practitioners. They can open their own clinics and see patients. However, instead of opening clinics or finding a job in a hospital, they take trainee courses to be specialists over five years. According to data in 1996 (Beck & Hwang, 1997: 29), 98% of general practitioners, who just obtained the licence of a physician, enter the training course to be a specialist every year. General practitioners in the course of being specialists cannot autonomously practise medicine, unless they serve as either army doctors or Public Health Doctors.

Oriental medicine introduced a speciality system a few years ago, and the first specialists were produced in 2002. Specialists in oriental medicine stay in oriental medical hospitals. For most oriental doctors, the concept of the speciality system is still controversial and engenders scepticism.

In addition, until 2000, pharmacists had functioned as general practitioners by prescribing medicines for minor illnesses, as well as by preparing medicines. These

¹⁶ According to a data in 1997, 90% of western physicians are specialists (Beck & Hwang, 1997: 29). In the latest data, the proportion is expected to be higher than this.

¹⁷ According to data in 1998, 47.6% of specialists open and manage their own clinics (KMA, 2000: 391). In recent years, the proportion of medical clinics to medical institutes has increased, and medical hospitals have suffered from a decrease in their medical staffs. Therefore, the rate of specialists, who work in medical clinics functioning much like as general practitioners, could be higher in the latest data.

situations show that the concept of specialists and general practitioners would clearly not work in Korean health care.

Secondly, until recently there has not been a clear division of function among the main three medical professions. Korean health care has admitted two different medicines - western medicine and oriental medicine. Until 2000, western physicians prepared and sold as well as prescribing medicines. Until then, pharmacists prescribed, as well as preparing and selling medicines. At the same time, oriental doctors prescribe and prepare herbal medicines. Therefore, these three medical professions were competing with each other, while having overlapping roles.

Thirdly, there is no strict referral system, which means medical clinics and medical hospitals compete with each other on almost the same basis. The government introduced the health care delivery system in 1989. Now when a patient wishes to receive care from a secondary hospital (general or special hospital), the patient must present a referral slip issued by the initial examining doctor, but can select any practitioner or health care institute. In addition, there are various exceptions in the delivery system in areas such as childbirth or emergency health care, dental care services, rehabilitation services, family medicine services, and health care services for haemophiliac. In these cases, any health care institute can be utilised without any limitation. Patients prefer large hospitals to small clinics in receiving medical services (MOHW, 2002). Under these circumstances, medical professionals and institutes compete with each other to attract patients by investing a large amount of money in cutting-edge medical equipment.

2.3.3 Recent Medical Conflicts between Medical Professions

The rapid increase in the number of medical professionals and unclear division of roles among medical professions and medical institutes presented above brought about two huge open conflicts between medical professions.

The first external medical conflict occurred in 1993 between oriental medicine and pharmacy over preparing and selling herbal medicines. Since the 1970s, there had been implicit conflictual situations between the two professions over this issue. Pharmacists wanted to expand their jurisdiction to preparing herbal medicines, while oriental doctors argued for their monopolistic right to do that. In every conflictual case, the government and the National Assembly attempted to evade or appease strife only by suggesting a recommendation or adding an ambiguous clause to calm down the conflictual situations (Shin & Ryu, 2002: 44-46).

The implicit conflict finally came into the open in 1993, when the provision prohibiting pharmacists from equipping a cabinet to keep herbal medicines in their own

pharmacies was deleted by the Ministry of Health and Welfare. Oriental doctors immediately and strongly opposed the government's decision, while prompting a government investigation of how and why the controversial provision became deleted. These reactions from oriental medicine subsequently caused pharmacists to demonstrate and strike. After severe strife between the two professions, the Pharmaceutical Act was revised to establish a new oriental pharmaceutical profession and to authorise pharmacists to prepare limited kinds of herbal medicines through a qualifying examination, for which the existing pharmacists could apply for only two years. This amendment also specified the separation between prescribing and dispensing of medicine, which would be enforced in 3 to 5 years, and which would produce another great medical disturbance.

Even after the settlement, conflict between the two parties went on for another three years. The issues were about the scope of medicine, the style of the qualifying examination for pharmacists, the persons who prepared examination questions, the position of oriental pharmaceutical departments in universities, and qualifications needed to take the examination for licensure to prepare herbal medicine. Expanding the scope of qualifications to all pharmacists and placing newly established oriental pharmaceutical departments in pharmaceutical colleges, not in oriental medical colleges, again triggered intense protests from oriental medicine. However, as oriental medicine accepted the government's plan for development of oriental medicine, the conflict abated.

The second medical conflict occurred in 1999 between western medicine and pharmacy over the so-called separation system. The principle of separation between prescribing and dispensing medicines was stipulated in the Pharmaceutical Act in 1963, but remained unenforced. In the workplace, pharmacists had prescribed for illness, as well as dispensed medicines, much like general practitioners; likewise, western physicians had not only prescribed for patients but had also prepared and sold medicines. There had been no in particular conflict between the two parties over their overlapping roles. However, specification of the separation in the revised Pharmaceutical Act, which established the first agreement between pharmacists and oriental doctors in 1994, began suppressing enforcement of the separation.

In 1998, President of Korea Kim Dae-Jung was inaugurated. As one of his election promises, the separation scheme began to be examined specifically. The difference of views between western physicians and pharmacists was serious, especially over the scope of applied medicines and medical institutes, and over the possibility of alternative or arbitrary preparation. Most of all, taking the right to prepare and sell medicines from western physicians would mean blocking their illicit income from pharmaceutical companies. At that time, the fee for medical services in the National

Health Insurance was exceedingly low, and the so-called *margin* or *rebate* from pharmaceutical companies constituted a considerable portion of income in medical institutes. Opposition from western physicians to the separation scheme was particularly strong and led to a conflict that began in November 1999. Even after beginning the new scheme in 2000, western physicians' collective actions against it continued. During the so-called Great Medical Disturbance, which lasted about three years, there were several western physicians' demonstrations or strikes and four reshuffles of Ministers of Health and Welfare. When Roh Mu-Hyun won the Presidential Election of Korea in December 2002, he specifically intended to reform health care and supported the separation system, causing the external conflict to diminish.

2.4 National Health Insurance

The National Health Insurance is another important factor in health care, which has influenced individual medical professions and their relationships¹⁸.

2.4.1 History of the NHI

In 1977, a social health insurance system was introduced in Korea. Its coverage rapidly expanded until 1989, when the government implemented a compulsory health insurance program for the entire population. Over a decade, three kinds of health insurance scheme developed; Health Insurance for Employees of Government and Private Schools, Health Insurance for the Self-employed or Regional Health Insurance and Health Insurance for Corporate Employees.

In 1997, the government integrated the organisations in charge of the two former health insurance schemes and in July 2000 merged them into one single national health insurance corporation, and the RBRVS (Resources-based Relative-value Scale) system as the reimbursement system and a contract system to set fees were introduced to the NHI. In July 2003, the funds of the individual national health insurance schemes were merged into one. An abstract of the history and development of the Korean health insurance system is in Table 2-5.

The National Health Insurance Corporation (NHIC) is the only insurer controlling the administration of insurance. The NHIC is responsible for managing the NHI, which involves keeping records of the insured and their dependents, collecting contributions, paying for health care services and operating other related projects. The Health Insurance Review Agency (HIRA) is responsible for reviewing health care fees

¹⁸ The contents of 2.4.1 History of the NHI and 2.4.2 Financing the NHI mainly came from the website of the Ministry of Health and Welfare in 2003 (<http://www.mohw.go.kr>).

and for evaluating medical professionals' health care performance and the health care services they provide to beneficiaries.

Table 2-5 History of National Health Insurance

	Until 1977, there had been 4 funds for corporate firms and 7 funds for the self-employed - all on a voluntary basis.
1977	A compulsory health insurance program was introduced for all industrial firms with more than 500 employees.
1979	Program expanded to government and private school employees, and to firms with more than 300 employees
1981	Program expanded to firms with more than 100 employees and to the self-employed on an experimental basis (one city and five rural countries)
1983	Program expanded to firms with more than 16 employees
1988	Program expanded to firms with more than five employees and to rural residents
1989	Program expanded to the urban self-employed : A compulsory national health insurance program for the whole population
1997	Organisational integration of 227 regional health insurance societies and the institution for government/private school employees scheme
2000	The organisations of health insurance for the self-employed also merged into National Health Insurance Corporation. Introducing RBRVS system and a contract system to set fees in the NHI
2001	The NHI Corporation stated financial difficulties of the NHI.
2003	Financial integration of three health insurance schemes

Source: National Health Insurance Corporation
(http://www.nhic.or.kr/english/development/main_development.htm)

The Ministry of Health and Welfare manages and supervises the overall system and policy with regard to the NHI, enacts laws and regulations on health insurance, and approves the annual plans and budgets of the NHIC and the HIRA.

2.4.2 Financing the NHI

Fund resources for the NHI are mainly from contributions paid by the insured and their employers with some government subsidies. Although the NHI operates under a single insurer, NHIC, the methods for contribution calculation are different between the two categories of the insured, namely, the employee and the self-employed. In the case of employee health insurance, contributions are based on the incomes of the insured, and are borne by both employee and employer¹⁹. For the self-employed insured, the contribution is calculated based on properties, income, motor vehicles, age and gender of the insured.

To curtail the overuse of health care services and to prevent patients from crowding in large urban hospitals, the NHI scheme requires co-payment for health-care

¹⁹ For ordinary employees, the employer pays 50% of the contribution and the employee pays the other 50%. For government employees, the Government, as their legal employer, pays 50% of the contribution, whereas employees pay the other 50%. For private school employees, the owners of private schools pay 30% of the contribution, subsidised by the government for 20%. The employees in private schools pay the other 50% (MOHW, 2003).

services by patients. A patient pays 20% to 55% of total health care charges. The co-payment proportion is different according to a kind of medical institute and medical service (MOHW, 2003).

When using a pharmacy, a patient must pay 30% of the dispensing fee and drug cost. When the total drug and dispensing fee is less than 8,000 Won [£ 4], the patient pays 1,000 Won [50 pence].

2.4.3 Payment for Health Care Services in the NHI

There are two kinds of medical services and two fee systems individually corresponding to them. Currently, for insured services, the Health Insurance Policy Deliberation Committee decides prices and the National Health Insurance Corporation (NHIC) and patients co-pay medical professionals. For non-insured services, individual speciality associations in western medicine, the national association of oriental medicine and of dental surgery “recommend proper prices (*WesternPhysician07*)”. Patients pay fully for the non-insured medical services.

The price of medical services in the National Health Insurance is far lower than that of non-insured medical services. Although a comparison is difficult between the different services, it is possible to compare fees for a medical service before and after being covered by the NHI. For example, before being insured, the fee for acupuncture was up to 30,000 Korean Won [£15]. When a basic kind of acupuncture was covered by NHI for the first time in 1987, the fee was 280 Won [14 pence]. Now, all kinds of acupuncture enter the national health insurance scheme, costing around 9,000 Korean Won [£4.5] (*OrientalDoctor4*).

Under the NHI, every legal health care institute is authorised to provide health services. Insured services are paid for through a fee-for-service system, in which there is an itemised cost for each health care service. Payment of health care claims is made by the National Health Insurance Corporation. The Health Insurance Review Agency reviews and evaluates claims submitted by the health care institutions and conveys the results to the NHIC.

The cost of drug and health care materials is paid directly to the person or entity, which has supplied the drug or health care materials to medical care institutes. Reports of the amount of drugs and health care materials and the name of the health care institute are submitted to the NHIC.

In 2000, the government introduced the RBRVS (Resources-Based Relative-Value Scale) as the reimbursement system for the National Health Insurance. The Ministry of Health and Welfare classified medical services into 3,214 items and marked a

relative value point for every medical service item. Individual prices of medical services are then calculated by multiplying each unit of medical services by a monetary value. Under the RBRVS system, there are two key elements in setting fees: the relative value points of individual medical services and a monetary value per unit of medical services. The relative value points of medical services are examined and decided in the Team of Relative Value Points under the Ministry of Health and Welfare. Under the present system, the most important element is considered as a monetary value per unit of medical services, which directly influences all items at the same time. In deciding a monetary value per unit of medical services, the government introduced a contract system²⁰.

Since 2000, the Director-General of the National Health Insurance Corporation and the chairman of the Medical Care Fee Contract Committee composed of the representatives of medical suppliers annually make a contract based on the monetary value of each unit of health care services. If they fail to reach a contractual agreement, a decision is made by the Health Insurance Policy Deliberation Committee (National Health Insurance Act, Article 42), which is composed of the representatives from providers of medical services, the insured and the government. So far, there has been no agreement between the Director-General of the NHIC and the chairman of the Medical Care Fee Contract Committee. Therefore, the true agency to set fees in the NHI is the Health Insurance Policy Deliberation Committee.

Table 2-6 shows the amount of payment for medical services in the National Health Insurance by the category of medical institutes for the first 6 months in 2002. Because medical institutes have another income from non-insured medical services as well as from patients as a part of co-payment in the National Health Insurance, Table 2-6 does not show the whole income for medical institutes. In addition, the payment per institute is only an average amount, which does not reflect distribution of income within individual categories.

Nevertheless, the table presents a few important points *in* the national health insurance. Individual general hospitals clearly receive the largest share of NHI funding. Individual oriental clinics receive least, and individual pharmacies receive slightly more NHI funding than individual western medical clinics. The individual proportions of total payment are 63% for western medicine, 4% for oriental medicine and 27% for pharmacy. The fact that income from non-insured items is unknown always causes controversies when setting fees for medical services in the NHI.

²⁰ Until 1999, fees in the NHI was set by the government, in terms of the agreement between Ministry of Finance and Economy and the Ministry of Health and Welfare. Based on the principle of price stabilisation, the Ministry of Finance and Economy was more influential in setting fees in the NHI (Park, 2003: S430-S431).

Table 2-6 Payment for Medical Services in the NHI (January to June 2002)

	Number of Institutes	Total Payment : Million Korean Won (proportion to total payment)		Payment per Institute : Million Korean Won	
SUM		9,191,417	[£ 4,595,708,500**] (100%)		
Western Medicine		5,785,824	[£ 2,892,912,000] (62.9%)		
Special General Hospital*	43	1,187,863	[£ 593,932,000]	27,625	[£ 13,813,000]
General Hospital	249	1,104,011	[£ 552,006,000]	4,434	[£ 2,217,000]
(Western) Hospital	785	573,499	[£ 286,750,000]	731	[£ 366,000]
(Western) Clinic	21,837	2,920,451	[£ 1,460,226,000]	134	[£ 67,000]
Oriental Medicine		385,982	[£ 192,991,000] (4.2%)		
Oriental Hospital	157	37,957	[£ 18,979,000]	242	[£ 121,000]
Oriental Clinic	7,218	348,025	[£ 174,013,000]	48	[£ 24,000]
Pharmacy	17,823	2,496,674	[£ 1,248,337,000] (27.2%)	140	[£ 70,000]
Dental Institutes & Others		522,937	[£ 261,468,500] (5.7%)		

Source: Health Insurance Review Agency (2002)

* The general hospitals with over 500 beds among general hospitals

** All GBP values were calculated by the author at the exchange rate of 2,000 Korean Won to GBP.

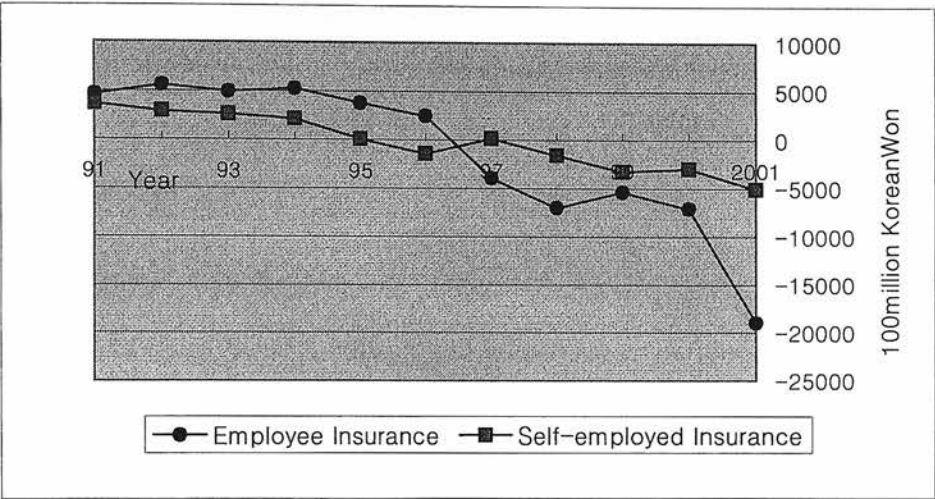
2.4.4 Financial Difficulties of the NHI

To make health insurance take root in its early stages, the low-contribution policy with a low payment system for medical professionals was inevitable in the last two decade. This policy resulted in many complaints from providers of medical services and in serious problems such as illicit income from pharmaceutical companies. In addition to low revenues, high expenditures of the NHI, which resulted mainly from a rapid increase in household incomes and the ageing population, advances in new technology in the health care sector and the expansion of benefits packages, have caused serious financial instability within the NHI since the mid 1990s (Shin, 2000; Shin, et al., 1999; Choi, H., 1997). The annual increase rate of expenditure in the NHI during 1994 to 1998 was 20.5% whereas the increase rate of contributions during that time was 12.2% (MOHW, 2003). Figure 2-3 shows the financial difficulty of the NHI in recent years.

Since 1996 or 1997, both the national insurance scheme for employees in private companies, private schools and government and the scheme for the self-insured, who own and manage their own shop or small company, have recorded deficits. By implementing the separation system in July 2000, the government increased payments to medical professionals in the NHI, which led to larger deficits. This caused increased tension among medical professions over the NHI. Particularly, western medicine and pharmacy have blamed each other for the larger deficit. The conflict between the government and

medical professions emerged as another issue; in order to improve the financial situation of the NHI, the government has attempted to cut the fee for medical services in the NHI since 2001.

Figure 2-3 Balance* of the National Health Insurance by Year (1991 to 2001)



Source: National Health Insurance Corporation (2002)

* Balance = Revenue – Expenditure

2.5 Conclusion

In this chapter, the development of the three main medical professions, the rapid increase in membership, unclear divisions of their functions and recent situations in the National Health Insurance were presented.

In Korean health care, western medicine is the mainstream with the largest number of members and capital. Their scientific knowledge and advanced technology have also given them the highest position in the medical field. However, oriental medicine, based on its long history and the image of a national heritage, and pharmacy, with its many members and a large proportion of women, whose positions have been high in female society, have emerged as western physicians' strong competitors.

In recent decades, individual medical professions have experienced a rapid increase in membership, which has led again an increase in medical institutes. In addition, there has not been clear division of roles between specialists and general practitioners, among the three medical professions and among medical institutes in practice. All these situations have made the competition among medical professions keener. The competition brought about two huge open conflicts between medical professions. The first conflict occurred in 1993 between oriental medicine and pharmacy and the second one broke out in 1999 between western medicine and pharmacy.

The introduction and expansion of the NHI made that competition even more severe. It particularly caused financial and professional difficulties in pharmacy, which became involved in the two open medical conflicts. Low payments for medical services in the NHI emerged as an open issue only with the beginning of the conflict over the separation system. Financial difficulties in the NHI have caused another controversy in the relationship among the medical professions.

All those situations would become fundamental backgrounds of the recent medical conflicts, which are analysed in Chapter 5 to Chapter 8.

CHAPTER 3. THEORETICAL APPROACH & FRAMEWORK

Chapter 3 discusses the theoretical background and framework of the study. In order to explore recent conflicts among medical professions in Korea, I use Abbott's theory contained in *The System of Professions* (1988), as the main theoretical background.

First of all, I examine which professional theories can explain the Korean case and explain why Abbott's theory is more persuasive as the theoretical background than are other professional theories. Some discussion of the development of the medical professional systems in China, India and Japan may help to show to what extent Abbott's theory can be applied to other Asian cases. Abbott's study on claiming jurisdiction of professions, the professional system and environmental factors of a professional system, which follow, suggests important points in analysing the four individual Korean cases.

Theories about the economic interests of professions and the government's role are also considered. Although Abbott considers the state's role only one of many environmental factors and hardly refers to monetary interests in his work, those issues are expected to be particularly important in explaining the Korean cases.

Based on Abbott's theory and on other studies about the economic interests of professions and the state's role, a theoretical framework is established. It starts with defining basic terms employed in the study and refining a few concepts and assumptions in Abbott's work. Then the framework is presented in order to explain the individual cases and the whole study.

3.1 Professional Theories and the Korean Case

3.1.1 Professional Theories for the Korean Case

The professional theories that can be applied to the Korean case will be divided into three groups.

Firstly, if one intends to explore medical conflicts in Korea from the perspective of the development or evolution of individual professions, early works on professionalisation are useful. Since Carr-Saunders and Wilson's study, *The Professions* (1934), other works on professions focused on the concept of a profession and the general process of being a profession, that is, professionalisation. For example, Greenwood identified essential elements in the ideal-type profession as the basis for a systematic theory that includes authority recognised by the clientele of the professional group, a code of ethics regulating relationships among professionals and clients or colleagues and a professional culture sustained by formal professional associations (Vollmer & Mills,

1966: 9).

Caplow (1954: 139-140) maintained that there was a predictable sequence in which professions would tend to develop. According to him, the steps involved in professionalisation are quite definite and have an explicit sequence that can be clearly illustrated. The first step is establishment of a professional association with definite membership criteria designed to keep out the unqualified. The second is a change of name, which serves the multiple function of reducing identification with the previous occupational status, asserting a technological monopoly and providing a title that can be monopolised, since the former is usually in the public domain. The third step is development and promulgation of a code of ethics, which asserts the social utility of the occupation, sets up a public welfare rationale and develops rules, which serve as further criteria to eliminate the unqualified and unscrupulous. The fourth step is a prolonged political agitation, whose object is to obtain public support for the maintenance of new occupational barriers. Concurrent with this activity is the development of training facilities directly or indirectly controlled by the professional society, particularly with respect to admission and final qualification; the establishment through legal action of certain privileges of confidence and inviolability; and elaboration of the rules of decorum found in the code and the establishment – after conflict – of working relations with related professional groups (Caplow, 1954: 139-140; Vollmer & Mills, 1966: 20-21).

However, there are limits when applying these early works on professions and professionalisation to the recent Korean cases. The main medical professions in Korea had already finished their professionalisation process before the 1960s. Although they came to be organisationally and politically more mature and developed through conflicts with other medical professions, that has been only part of the phenomena in the recent medical conflicts. Therefore, the theory of professionalisation explains only a small part of the Korean case.

Secondly, if one intends to research the recent medical conflicts in Korea from the perspective of professional *power* or pecuniary interests of professions, professional studies by so-called monopolists or power theorists could be relevant. Freidson is considered a founder of the power theory in professionalism. Freidson (1970a, 1970b) argued that dominance and autonomy, not collegiality and trust, were the hallmarks of true professionalism. He placed in the centre of his analysis of professional dominance the idea that occupations gain recognition by obtaining the support of powerful political and economic elites. While Freidson's work became an important model for the sociology of the professions in the US, Johnson's work (1972) which emphasised the role of power in establishing and maintaining control over professional work emerged as a leading

study of professional power in the UK.

In Larson's *The Rise of Professionalism* (1977), professions were explicitly market organisations attempting the intellectual and organisational domination of areas of social concern. Larson studied professions linked to the class system of capitalist societies and analysed professionalisation as a collective mobility project in which professions seek to improve their economic position as well as their social standing or prestige. While Freidson considered the medical profession as pursuing its own rather than capitalist interests, Larson emphasised the latter more by arguing that occupational ideologies must match capitalist perceptions if professional status is to be achieved (Larkin, 1983: 12).

The relationship between professions and the state has been an important issue for monopolists. They have focused on the state's active intervention in professionalisation or professional work by emphasising that professional expertise has been dependent on government for recognition, licence and legitimation

The monopolist theory of professions and studies particularly on monetary interests in medical professions will be useful for this research, because financial concern was an important aspect of the medical conflicts in Korea, as implied in the pilot survey of this study (4.3.1 Learning from the Pilot Survey for Developing Topics, pp.60-63) and shown in data collected during the fieldwork. The relationship between professions and the state in the monopolist theory will also help to set up the theoretical framework of this study. Therefore, I will employ a few points from these works as a theoretical background.

However, the monopolist theory cannot show the whole Korean case. They focus their arguments on a certain topic, not paying sufficient attention to a larger social structure. To understand the Korean case, where the three main medical professions have individually faced each other for diverse reasons in complicated situations, a more systematic and longer-term perspective is required.

Thirdly, in order to research the conflictual phenomena in Korea from the perspective of the professional system, Abbott's study supplies a persuasive theoretical background. While previous studies on professions emphasised concepts and characteristics of individual professions and professionalisation, or of an individual profession as an actor with an active motivation of dominance, Abbott considered professional phenomena from the perspective of a whole entity, that is, a professional system. Abbott (1988) asserted that a fundamental fact of professional life is interprofessional competition, which focuses on the whole professional system and its environments, not on individual professions. According to Abbott (1988), only the study of competition can tell why certain professions emerge and why they sometimes succeed

and sometimes fail.

The purpose of this research is to explore how the system of medical professions changed through a series of the conflicts in Korea by supplying what happened during the conflicts and explaining why they occurred. Relationships among Korean medical professions in recent years appear to reflect typical inter-professional conflicts based on jurisdictional changes, as Abbott (1988) explained. Abbott's theory is expected to explain the complex and dynamic Korean case, which is related to diverse factors, providing a comprehensive and systematic perspective. Then, I will use Abbott's study, *The System of Professions* (Abbott, 1988), as the main theoretical basis of the research.

Therefore, the theoretical background for this research is mainly composed of Abbott's theory of the system of professions but complementarily it also includes a few points from studies on pecuniary interests of professions.

3.1.2 Professional Theories for Other Asian Countries

While there have been many attempts to explain medical systems in western countries using professional theories, Asian cases appear to have been omitted from that trend. Examining the Chinese, Indian and Japanese cases will imply whether or not and how professional theories would be applicable to non-western cases. This comparison is also expected to have implications for explaining the Korean case.

China has a medical professional system, in which western medicine and traditional Chinese medicine are combined. In the early 20th century, as the Republican government chose an exclusive policy toward western medicine, Chinese medicine was almost legally abolished as 'superstitious' and 'backward' practice (Unschuld, 1985: 250). With the establishment of the Communist government in 1949, western medicine was politically judged in conjunction with the campaign against bourgeois attitudes, and Chinese medicine started being re-evaluated. Western drugs were still expensive and difficult to obtain. Towards the end of the 1950s Mao Zedong declared that Chinese medicine should be explored and improved, thus encouraging the combination of Chinese and western medicine. In the early 1980s, the government adopted the policy of the "Three Roads", under which both western and Chinese medicine are granted the freedom to exist or develop along their respective lines. A third road is seen in a conjunction of western and Chinese medicine wherever this appears feasible (Unschuld, 1985: 261).

India had a medical system dominated by western medicine, which arrived when the British first occupied India. After the Independence in 1947, the Indian National Congress took a decision to absorb practitioners of traditional medicine into the formal health system. India is considered one of the very few countries which early on

recognised their pre-colonial medical systems and financed their research and development with official support by the Ministry of Health (Davis and Chapman, 2001).

The promotion of traditional medicine in India has basically been undertaken through a strong policy decisions taken at the highest level. The goal of Indian health policy at the time of independence was universal and free primary health care for all (Gupta and Chen, 1996: 19), looking toward a socialised system of health services in which public health provisions dominated and eventually replaced private medical practice (Jeffery, 1988: 112). Because western medicine was still too expensive to meet the basic health needs of the Indian population, indigenous medicine was expected to achieve the government's goal²¹. The movement for traditional medicine is judged to successfully establish parallel sets of institutions devoted to indigenous and western learning.

The medical professional system in Japan has kept a stable situation compared with the other two cases, where western medicine remains the dominant profession (Powell and Anesaki, 1990: 200-201). Since 1868 when the Meiji government decreed that only physicians trained in western medicine were to be legitimised, government policy was clear-cut modernisation of medical education and practice. Japanese militarism and imperialism during the early 20th century led western medicine to the supreme position in health care (Powell and Anesaki, 1990: 51). Only in the last few decades, have formal training programmes, curricula and state examinations for the other health practitioners including traditional medicine²² and pharmacy been established and the nature of their practice and responsibilities defined (Powell and Anesaki, 1990: 222).

The three Asian cases show that the main issue in their medical professional systems has been the relationship between western medicine and traditional medicine²³. As in Korea, western medicine was first introduced to other Asian countries mainly by European or American missionaries. While a small number of reformist elites tended to favour and accept western systems and knowledge, including western medicine, there

²¹ There were also cultural and philosophical difficulties for many Indians in accepting western medicine (Arnold, 1996: 1075-1076).

²² With the Meiji reform, traditional Japanese medicine lost official support. Now the training for practitioners of traditional therapies is covered by professional curricula and programmes and they should pass prefectural examinations to obtain a licence to practise (Powell and Anesaki, 1990: 223).

²³ In all the three cases, pharmacy has had a weak influence in health care. In China, pharmacy was not recognised as an important agent in the medical profession by the public, other medical professions and the government (Yip, 1995: 161-162). A recent report issued by an Indian government committee, Committee on Petroleum and Chemicals, also implied the weak position of pharmacists in India (Bhise, 2003). The fact that the separation system in Japan is not entirely enforced as the law specifies reflects the weak position of pharmacy under the influence of western medicine (JPA, 2000).

were still strict isolationists, who attempted to protect their own national traditions from the western influence (Powell and Anesaki, 1990: 19-26; Jewell, 1983). After conflicts, often involving political disturbances, between western-oriented practitioners and proponents of a more isolated position²⁴, western-trained elites, came to power in China, Japan and Korea, committed to a reform process involving the imposition of western models and institutions on all aspects of their societies. These governments regarded western medicine as the only legal and legitimate form of medical practice.

Thereafter each country formed its own medical professional system. While the Japanese government has kept that exclusive policy toward western medicine, China and India have actively supported their traditional medicine since the mid 20th century. In particular, the state's goal or political purpose strongly influenced the medical professional system. In changing the policy of traditional medicine, every government played a role of active interventionism: Mao's communist government implemented a policy to rejuvenate Chinese medicine and succeeded in combining it with western medicine; the Indian government strongly supported indigenous medicine following independence, with its socialist health care policy; and the Japanese government consistently needed development of western medicine, while undertaking war with its military expansionist policy.

The situations in these three cases suggest the governments have led and controlled the medical professional systems and the changes to them. It implies that the monopolist theory of professionalism can be more useful in explaining the three cases than Abbott's theory, in which the government is regarded as an external environmental factor among diverse influences. Abbott's theory, which tends to emphasise the professions' active roles and relationships between them more than the government's initiating role, would be more useful for the Korean case than for the three Asian countries.

3.2 Abbott's Theory of the System of Professions

The starting point of Abbott's (1988) theory is that the central phenomenon of professional life is the link between a profession and its work, that is, its jurisdiction. Based on his argument, each profession is bound to a set of tasks by ties of jurisdiction, the strengths and weaknesses of these ties being established in the processes of actual professional work. Since none of these links is absolute or permanent, the professions

²⁴ During the 19th and the early 20th century, political and social disturbances in China (Spence, 1999: 139-243; Chinen-Nung, 1956: 8-11), Japan (Gordon, 2003: 46-76) and Korea (Tennant, 1996: 198-243) are similarly identified, when they were enforced to open trade with western countries.

make up an interacting system. Professions compete within this system, and a profession's success reflects as much the situations of its competitors and the system structure as it does the profession's own efforts. In the system of professions, where tasks are created, abolished or reshaped by external forces, professions are never seen alone, and they are also not replaced by a single encompassing category of the professions. They exist in a system (Abbott, 1988: 33).

Abbott's theory can be presented largely as being divided into two parts: one is about claiming jurisdiction of professions and the professional system; and the other is about the environmental factors, which influence jurisdictional changes in the professional system.

3.2.1 Claiming Jurisdiction of Professions and the Professional System

According to Abbott, a profession asks society to recognise their exclusive rights in claiming jurisdiction. To secure jurisdiction is to ensure rights of monopoly of practice and of public payments, rights of self-discipline and unconstrained employment and control of professional training, recruitment and licensing (Abbott, 1988: 59). Abbott suggested that jurisdictional claims could be made in the following three arenas: public opinion, the legal system and the workplace.

First, a jurisdictional claim made before the public is generally a claim for the legitimate control of a particular kind of work (Abbott, 1988: 60-62). This control means a right to perform the work as professionals see fit, to exclude other workers and to dominate public definitions of the tasks concerned. A jurisdictional claim in public opinion means a claim of social and cultural authority (Abbott, 1988: 60). The arena of public opinion is a pathway to the legal arena, another battlefield of professional conflict. Professions build their images in the public arena and then pressure the legal system with them.

Second, jurisdictional claims in the public arena are heightened in the legal system (Abbott, 1988: 62-64). Contests for legal jurisdiction occur in the legislature, the courts and the administrative or planning structure. Here the contents of the claim of jurisdiction become more specific. They may include the granting of a monopoly on certain activities, on kinds of payments by third parties and control of certain work settings.

Third, in the workplace, jurisdiction is a simple claim to control certain kinds of work (Abbott, 1988: 65-67). There is usually little debate as to what the tasks are or how to construct them in the workplace, because there is normally a well-understood and

overwhelming flow of work. However, because of the actual complexity and diversity of professional works in practice, boundaries between professional jurisdictions tend to disappear in worksites (Abbott, 1988: 65). In this case, superordinates in a professional system emphasise clarity of jurisdictional boundaries towards subordinates, while subordinates emphasise assimilation with superordinates (Abbott, 1988: 67).

Every profession aims not only to possess its own jurisdiction, but also to defend and expand it. However, since there is a system of professions, there are various alternatives to full jurisdiction under constrained real circumstances: subordination, division of labour, intellectual jurisdiction, advisory jurisdiction and client differentiation (Abbott, 1998: 71-78).

The most familiar of limited settlements is subordination (Abbott, 1988: 71-72). Abbott presents the relationship between medicine and nursing as an example. Maintenance of subordination emphasises formal – legal and public – subordination, which is less vulnerable to challenge than the assimilated realities of the workplace. However, in the workplace, maintenance of subordination requires a complex symbolic order, such as the use of titles and respect language or the wearing of uniforms.

A settlement by division of labour means a division of the jurisdiction into functionally interdependent but structurally equal parts (Abbott, 1988: 73-75). However, maintenance of a settlement by division of labour is difficult, because the degree of assimilation between the two groups is normally great, and boundaries are correspondingly obscure.

Client differentiation settlements (Abbott, 1988: 77-79) usually reflect the relation between the size of the profession and the available demand for its service. Normally differentiation appears when demand suddenly outstrips available professional numbers, which is an external force to the professional system. This method of settlement occurs in the workplace and is implicit rather than explicit.

Abbott emphasised that the social organisation of professions affects the kinds of jurisdictional claims they make and their success in achieving those claims (Abbott, 1998: 79-85). He erected the following assumptions with regard to the social organisation of a profession. First, the more strongly organised a profession is, the more effective its claims to jurisdiction. Second, professional organisation, in particular the existence of a single, identifiable national association, is clearly a prerequisite of public or legal claim. Third, in a particular way, less organized professions have certain distinct advantages in workplace competition. Because they lack a clear focus and perhaps a clearly established cognitive structure, they are free to move to available tasks.

Abbott's theory of a professional system began with the proposition that

professions constitute an interdependent system because of the exclusiveness of jurisdiction. Therefore, in such a professional system, a move by one profession inevitably affects others. Jurisdictional change in a professional system would start in two general ways – by external forces opening or closing areas for jurisdiction and by existing or new professions seeking new ground. The jurisdictional changes lead to chains of disturbance in the professional system (Abbott, 1988: 90-91).

3.2.2 Environmental Factors of a Professional System

Abbott paid attention to factors which would change individual professional jurisdiction and then a whole system. In his study, Abbott showed how a variety of forces - some internal to professions, some external to a whole professional system and some inherent in a system itself, led to disturbances in a system. He investigated how these disturbances propagated and how they were absorbed by taking historical examples in the UK, the US, Germany and France (Abbott, 1988: 33-34).

3.2.2.1 Internal Factors of the Professional System

Various forms of internal differentiation affect interprofessional relations and then the system of professions primarily by generating or absorbing system disturbances or affecting the interconnections between professions. Internal differences are specified by intraprofessional status, by client, by organisation of work and by career patterns.

Professionals accorded the highest status by their peers are those who work in the most purely professional environments (Abbott, 1988: 118). Front-line professionals who make the first professional contacts with clients, and whom the public usually venerate, are generally at the bottom of status rankings within their professions. Under these circumstances, professions tend to withdraw into themselves, away from the task for which they claim public jurisdiction. Abbott called this phenomenon professional regression and said it is irreversible (Abbott, 1988: 119). Even under clear threat, regressing professions do not eradicate the internal status distinctions that cause regression. Internal stratification in professions thus generates system disturbances and absorbs them. Internal status differences combine with differences in clients and in work organisation to create wide disparities in income, power and prestige within professions.

Client differentiation is often important in inter-professional relations (Abbott, 1988: 122-124). Two professions in superordinate-subordinate relation may occupy a common jurisdiction, with the superordinate generally serving the higher-status clients and the subordinate the lower-status ones. Differentiation in clients affects intraprofessional and interprofessional relations and then the professional system.

society and social movements (Abbott, 1988: 143-176). The development of machines and technology has created large new fields of potential professional work. The rise of large organisations has also reshaped professional work. In both private and public sectors, large organisations have generated work both internally and externally, which has demanded enormous inputs of professional services. In addition, social movements have often identified social problems, which later become potential expert work. Professionals are often leaders in these movements; in other cases lay leaders gradually turn into professionals.

Abbott emphasised that an important characteristic of professions during the 20th century was a more bureaucratic organisational form, a change particularly noticeable in professional workplaces, but also characteristic of professional associations (Abbott, 1988: 150). Bureaucratisation has had diverse effects on professions and their competition for work. The creation of professional organisations with internal divisions of labour has largely affected competition within professions, although on occasion such organisations have favoured certain professions over others (Abbott, 1988: 157).

B. Who Regulates Professions?

Another important social force is who would mainly involve in and regulate professions (Abbott, 1988: 157-167). This point is particularly important when examining complicated situations in the Korean case.

In different countries and at different times, the main audience of the professional system has changed among professions themselves in the workplace, the public in the arena of public opinion or the government in the legal system. Here, Abbott shows his interest in the role of the state²⁵. European continental countries such as France have experienced a long dominance of the legal arena in professional systems. France is a typical interventionist state and its policy is largely ministerial, where the ministries or the executives are more influential than the legislature or public opinion in professional policies. In the US, public opinion has traditionally had a strong influence on regulating

²⁵ The relationship between professions and a government or the state has been an important issue in professionalism. Freidson is considered as the first sociologist to provide a systematic and sophisticated view of the relationship between the state and professions (Johnson, 1995: 9). Freidson argued that while a profession may be entirely subordinated to the state when it comes to the 'social and economic organisation of work', nevertheless, modern states 'uniformly' leave in the hands of professions control over the technical aspect of their work (Freidson, 1970: 24). He suggested that state intervention does not undermine the autonomy of technical judgement so much as establish the social or moral premises on which the judgement of illness is based (Freidson, 1970: 43). According to Larson, the state, the supreme legitimising and enforcing institution, was fundamental to securing the conditions of professionalisation. He claims that state-backed monopoly was the mechanism through which professions protected themselves against the undue interference of the state (Larson, 1977: 53).

professions. British regulation of professions has remained a legislative affair and Parliament takes minimal actions toward the professions. Abbott presents that there is some evidence that the US and the UK are both moving in the French direction (Abbott, 1988: 157-164). The medical area has long been under intense public control in the UK and is moving towards such control in the US.

In the meantime, according to Abbott (1988: 167-168), some professions employ co-opted external authority in interprofessional competition. That can cause major changes in competition, for the new corporate society has vastly increased the amount of external authority available. This changing balance between professions and external powers is, in turn, related to another important development, the emergence of dominant, oligarchic professions. The situation in which a few professions control an entire system can be defined as a condition of oligarchy. Under oligarchy, new work is not allocated by competition, but simply by power. Such professions typically control numerous subordinate groups in widely spread jurisdictions, and they generally rely on co-opted authority. As fewer and fewer professions control more and more, interprofessional competition becomes less and less important.

3.2.2.3 Cultural Environmental Factors

The cultural structures that relate professions to their work have also impacted powerful changes. Cultural factors, which have transformed interprofessional relations, include professional knowledge, the moral foundations of jurisdiction and the emergence of the modern university.

Professional knowledge is an external force shaping interprofessional competition. Knowledge change divides into two somewhat contradictory components. One involves the addition of new knowledge and the other is replacement of the old (Abbott, 1988: 178). The two knowledge-change processes – growth and replacement – have contradictory effects on professions (Abbott, 1988: 179). Growth pressures them to subdivide, in order to maintain at a constant level the amount of knowledge a given professional must know. Replacement pressures them towards abstraction, since abstractions will last longer than knowledge of specific facts and methods.

Legitimizing work connects professional diagnosis, treatment and inference to central values in the larger culture, thereby establishing the cultural authority of professional work. However, values change. Like other external forces, their changes affect the professions not directly but through the system's structural relations (Abbott, 1988: 184). The moral foundations of jurisdiction, the grounds of legitimacy for professional claims, are also important.

The major shift in legitimation in the professions has been from a reliance on social origins and character values to a reliance on scientisation or rationalisation of technique and on efficiency of service. The replacement of gentlemanliness by scientism, efficiency and accountability has drastically reshaped the contents and results of interprofessional competition. This change reflects value shifts in the larger culture and has steadily pressured professions to move towards these legitimacy bases or face erosion of jurisdiction (Abbott, 1988: 195). Few professions have lost major jurisdiction by refusing to adopt new forms of legitimacy, perhaps because few have, in fact, retained old forms, and because those few happen to be extremely powerful. Thus, while legitimacy values have shifted markedly over the modern history of professions, and while they differ considerably from country to country, they have surprisingly small effects on the actual history of jurisdiction. New values serve as convenient ideologies for insurgent or new groups.

He also pointed out the emergence of the modern university as a cultural factor (Abbott, 1988: 195). Professions rest on knowledge and higher education has been considered the most important element of professionalism. Most professional education occurs in universities, which is the seat of knowledge in modern societies. Universities play several roles in professional life. They serve as legitimators, providing authoritative grounds for the exclusive exercise of expertise, housing the function of knowledge advancement, and enabling academic professionals to develop new techniques outside of practice, as well as to train young professionals.

Abbott attempted to explain how, when all these structures are present, interprofessional conflicts occur and internal change impacts external position. In addition, he attempted to show why the general forces of bureaucratisation, knowledge change and other factors have not uniform, but highly idiosyncratic, effects on professions - effects shaped by internal and system forces, as well as by professional choices. The system model achieves a theory of that contingency. In addition, the model achieves that theory within a much wider context than has been previously theorised.

However, Abbott's theory has some weak points to be reconsidered or refined. I will present them in 3.4.2 Refining Abbott's Concepts and Assumptions (pp.52-55), setting the theoretical framework for the research.

3.3 Other Theoretical Backgrounds: Theories on Professions' Economic Interests & Theories on the State's Role

First of all, the pecuniary interest of professions, or the financial matter is the point that Abbott hardly refers to in his work. However, in explaining the Korean cases, it cannot be

ignored. There are plenty of studies on the monetary issues of professions and I will present a few works, which explain the Korean case.

Parsons argued that professionals are as self-interested as any other successful actors in the contemporary capitalist economy, but the interests they pursue are status, power and reputation, rather than wealth (Parsons, 1954). Beginning in the 1960s, this Parsonian view of professionals' interests has been criticised from all academic quarters. Sociologists, historians and philosophers of the professions have dismissed Parsons' vision as naïve and have instead, described professionalism as a cynical collective-mobility project, designed to secure wealth for professionals by means of monopolisation and supply restriction (Latham, 2001: 297-298).

In the sociological field, Weber's analysis of economic action and, particularly, his approach to monopolies have had substantial influence on a number of theorists. According to Weber (Roth & Wittich, 1968: 339-341), virtually all groups engage in economic action such as the satisfaction of wants for scarcities, including the social relationships necessary for pursuing satisfaction. Since most groups, even those without primary economic goals, require scarcities to achieve their goals, economic action is a general feature of social life. Weber argued that because economic action is directed toward the acquisition of scarcities, groups tend to become conflict groups, which may engage in violent or peaceful conflict, depending on the application of physical force (Berlant, 1975: 44-45).

The central significance of Weber's theory of monopolisation lies in its analysis of the manner in which group organisation is able to help individuals further their interests. As the number of competitors within an activity encroaches upon the profit span, an interest in the exclusion of some competitors is created. Concerted action for closure may take the form of a political community. Apparently, the most efficacious means of closure is for the associational group to persuade the legitimate agents of force within a political community to recognise and enforce the group's monopolistic claims. It then becomes what Weber calls a legally privileged group, a group with a legal privilege to hold a monopoly (Berlant, 1975: 48).

Larson (1977) more directly points out economic interests of professions. According to Larson (1977: xvii), professionalisation is an attempt to translate one order of scarce resources – special knowledge and skill – into another – social and economic rewards. To maintain scarcity implies a tendency for monopoly of expertise in the market and of status in a system of stratification (Macdonald, 1995: 9).

Contemporary social theorists study professionals' behaviour of pursuing financial benefits mainly from the perspective of professionals' individual motivation.

Professionals have mixed motives in all areas of their work: compensation motives (income, recognition), craft motives (commitment to excellence) and moral concern (caring, integrity) (Martin, 2000). These multiple motives interact in complicated ways, usually reinforcing each other but occasionally pointing in opposing directions. In most conflicts of interest, compensation motives threaten responsibilities within professions and organisations, as Carson points out (Martin & Gabard, 2001: 315-316).

In the meantime, there are studies which attempt to explain monetary interests of professions for contextual reasons. Some studies, such as those by Latham (2001) or Rodwin (1993), point out physicians' monetary motivation under the fee-for-service system. As Latham (2001: 285) comments, a physician, as the patient's purchasing agent under the fee-for-service system, has a duty to assist a patient in making prudent choices among medically relevant health care services. However, the physician also has a pecuniary interest in advising the patient to make more extravagant purchases than a disinterested purveyor of services might counsel. Latham argues that much of the conflict of interest present in the fee-for-service situation could be eliminated by enforcing a separation of physicians' diagnostic and prescribing functions from their treatment functions (Latham, 2001: 186-187).

Physicians also become interested in diverse gifts and benefits presented by pharmaceutical firms. The American Medical Association's Council on Ethical and Judicial Affairs has attempted to limit physicians' conflicts of interest created by pharmaceutical marketing practices by promulgating voluntary guidelines (Latham, 2001: 294-297).

In addition, the development of modern medicine requires the money economy to penetrate nearly all facets of the medical care system. There is more work to be done that requires longer and more costly training. Medicine has developed an array of powerful, expensive tools and equipment. The range of effective medical procedures, diagnostic tests, pharmaceutical products and medical equipment has burgeoned. Physicians rely more heavily on capital-intensive equipment and diagnostic tests. These changes increase the cost of medical services, and as a result, physicians' clinical decisions affect larger sums of money. Changes in technology and the cost of medical care illustrate the commercialisation of medicine (Rodwin, 1993: 12).

The traditional principles of economics have a neutral position to professionals' economic motivation. Economists assume that doctors are much like other people and are not paragons of virtue who operate independently from their economic environment. Therefore, their actions are influenced by monetary and non-monetary rewards. Economists expect doctors to maximise their own utility functions subject to the

constraints they face. Elements in the utility function may be many and varied, but they are likely to include income, work effort, peer group approval and public recognition. (Cullis & West, 1979: 14-15).

Based on a survey of over 300 Health Maintenance Organisations of all types, Hillman, et al. (1989) examine the impact of alternative physician compensation schemes on the utilisation of medical services and firm profitability. Overall, the results indicate that financial incentive affects the medical decisions of physicians and, therefore, the utilisation of medical resources. However, this is not to suggest that physicians necessarily jeopardise the welfare of their patient; rather, in some circumstances, physicians consider their own self-interest when making marginal clinical decisions (Santerre & Neun, 1996: 367-368).

On the contrary, works in political economy more actively criticise physicians' pursuing money. The physician control model suggests that physicians distort the allocation of resources to advance their own self-interest. Consumers are relatively ill informed concerning the proper amount of medical care to consume, because there exists an asymmetry of information regarding the various health care options available. The asymmetry forces consumers to rely heavily on the advice of their physicians for guidance. This implies that physicians are not only the suppliers of medical services but also play a major part in determining the level of demand for those services. This rather unique situation puts physicians in a potentially exploitative situation. Imperfect information allows the physician to abuse his or her advisory role by recommending unnecessary services for which remuneration is forthcoming. It may be possible for physicians to manipulate the demand curves of patients to advance their own economic interests (Santerre & Neun, 1996: 226-228).

The relationship between the state and professions is another less-discussed topic in Abbott's work. It is instead one of the monopolists' main concerns.

Freidson argued that while a profession may be entirely subordinated to the state when it comes to the 'social and economic organisation of work', nevertheless, modern states 'uniformly' leave in the hands of professions control over the technical aspect of their work (Freidson, 1970: 24). He suggested that state intervention does not undermine the autonomy of technical judgement so much as establish the social or moral premises on which the judgement of illness is based (Freidson, 1970: 43).

According to Larson, the state, the supreme legitimising and enforcing institution, was fundamental to securing the conditions of professionalisation. Larson's purpose was to examine how professions organised themselves to attain market power.

For her, professionalisation is the process by which producers of special services sought to constitute and control a market for their expertise (Larson, 1977: xvi-xvii).

The professional project tends toward the monopolisation of opportunities for income in a market of services or labour and toward the monopolisation of status and work privileges in an occupational hierarchy (Larson, 1977: 51). Eliminating pseudo-professions is significant to the monopolisation of expertise. In Larson’s logic, to secure a monopolistic position of a profession and its autonomy, state intervention or shelter is essential. She claims that state-backed monopoly was the mechanism through which professions protected themselves against the undue interference of the state (Larson, 1977: 53).

With regard to the state’s role, Abbott considers the state mainly as an audience for professional claims (Johnson, 1995: 17). In his work, the state is only an environmental factor in the system of professions: that is, an external agent made up of the legislature, the courts and the administrative or planning structure (Abbott, 1988: 62-63). Abbott’s perspective on the state might pay too little attention to the importance of the state. Considering the fact that the government has still played as important a role as other environmental factors in the Korean case, it is expected that the monopolists’ perspective on the state’s role will be used to supplement Abbott’s theory, which provides the main theoretical background of this study.

Table 3-1 summarises the specific topics in the theoretical background for the research; they come mainly from Abbott’s work and, complementarily, from other studies on pecuniary interests of professions. This is a base that establishes a theoretical framework and assists in the development of interview questions during the fieldwork.

Table 3-1 Research Topics from the Theoretical Background

Main Topics	Subtopics or Components
Jurisdictional Conflict	- claiming jurisdiction - settlement of conflict
Internal Factors	- organisational features of individual medical professions - stratification & dominant power in the system of medical professions - <i>financial pressure in the system of medical professions</i> *
Social Factors	- development of technology - social movements - <i>government’s role</i> * - public opinion - <i>financial pressure to medical professions</i> *
Cultural Factors	- changing professional knowledge - changing values and morality - educational or training system

* Supplemented by other studies

3.4 Theoretical Framework for the Research

3.4.1 Defining Terms



Before establishing a theoretical framework, concepts or terms employed in the study must be defined. Most of all, there are controversies about which groups are or should be considered medical professions. In the workplace, western physicians are reluctant to accept oriental medicine and pharmacy as medical professions. Oriental doctors do not want to call pharmacists professionals. These attitudes were also revealed during the interviews. Based on the Medical Services Act, western physicians and oriental doctors were still denying that pharmacists are professionals. The Medical Services Act does not include pharmacists in the scope of “medical persons”, but includes doctors [western physicians], dentists, herb doctors [oriental doctors], nurses and midwives as professions, who have been licensed by the Minister of Health and Welfare (Medical Services Act, Article1, Paragraph1). The Health and Medical Basic Act newly enacted in 2000 has used a new term, “health and medical persons”, which includes pharmacists. However, according to interview data, western physicians and oriental doctors are not eager to accept it.

In this research, I use the concept of medical professions, indicating all the three main provider groups of health care in Korea: western medicine, oriental medicine and pharmacy. In spite of controversies, there is no doubt that these three groups have been the most influential and important providers of health care services in Korea.

Then, the three medical professions and their members will be presented as follows in the thesis: western physicians in western medicine; oriental doctors in oriental medicine; and pharmacists in pharmacy. Although there are other names for them in practice and in other studies, particularly for oriental medicine²⁶ and its members, those words suggested just above will be used consistently.

3.4.2 Refining Abbott's Concepts and Assumptions

As presented in the previous sections, I will employ Abbott's theory of the system of professions as the main theoretical background. However, there are a few points in Abbott's work, which must be reconsidered and slightly changed for the research.

First of all, as Macdonald (1995: 16) briefly commented, Abbott does not particularly define what *system* is and what its scope or boundary is. Sometimes Abbott uses this word to imply a certain field, as in ‘a legislative system’. This different usage does not appear to matter, because readers may understand what it points out, and it may not cause any confusion. However, it is an unclear concept of a system, as in ‘the system of professions’, the main topic of the work. His loose concept and scope when explaining

²⁶ Korean Medicine, Korean Traditional Medicine or Korean Oriental Medicine is also commonly used in practice and in other studies.

a professional system subsequently leads to confusion, particularly in understanding something *internal* or *external*. He mainly uses *system* to indicate a whole set composed of individual professions. However, in some cases, he uses the word *system* to indicate *subsystem*, that is, a certain individual profession. Here, I make clear the concept of the system of medical professions first.

There are plenty of studies about the concept and characteristics of a system in social sciences. The fundamental and general concept of an open system and its characteristics can be applied to this study. An open system is defined as a set of objects or entities that interrelate with one another to form a whole under environments (Littlejohn, 1983: 29). A system is characterised by many attributes (Krone, 1980: 14; Katz and Kahn, 1966: 23-30; Littlejohn, 1983: 41-45; Monge, 1977). Systems are separated from environments by boundaries; and they interact with their surrounding environments; the process of interaction is composed of input from the environments into the system, throughout the system, output from the system into the environments and feedback through the environments for new input. All these processes make a cycle and continuously operate. Using these general characteristics of a system and with some assumptions for the study, now I define the concept of the system of medical professions as follows.

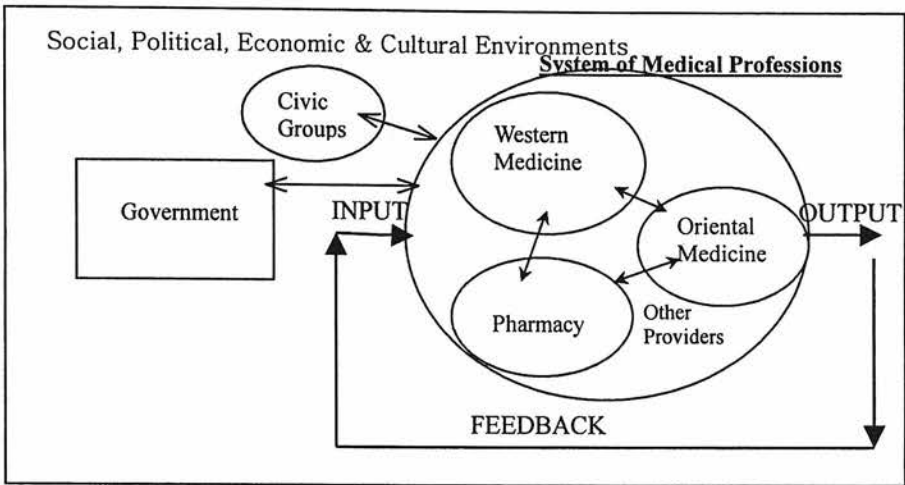
Firstly, the system of medical professions in this study is defined as a set of medical professions surrounded by environments. Different medical professions interact with each other and with environments, either through conflict or cooperation, and the system interacts with the environments.

Secondly, the environments include social, political, economic and cultural situations surrounding the system. The government and civic pressure groups are the most important players in environments. These are important not only in the conflictual situations of Korean health care in practice. In Abbott's theory, the government explains conflictual situations in *the legal arena*, while civic groups show those in *the public arena*. By examining their functions and comparing them with each other, the government's role and its health care policies are analysed. Regarding the scope of the government, I specify as far as possible who is a player in the government among political members, ministries and government officials. If there is no specific comment, government means all those players in the public system.

Thirdly, based on the system theory, the input of the system of medical professions is diverse environmental factors and their changes including government's policies, which influence medical professions and sometimes cause conflict. The output is the medical professions' decisions and actions to respond to environmental factors,

resulting in other changes in the environments and another input.

Figure 3-1 The System of Medical Professions and Its Environments



In addition to the concept of *system*, there are two assumptions in Abbott’s study to be reconsidered. Firstly, Abbott assumes that the competition model holds ‘in the same way’ throughout the period discussed – roughly from the Industrial Revolution to the present. However, in my study, the important question is this: does the competition model hold in the same way through the recent four conflicts in Korean health care in the last decade; does it change through the conflicts? Without assuming anything about the direction of the professional competition, I analyse the situations and the phenomena of competition or conflict among medical professions.

The other assumption by Abbott is that individual professions have a strong existence and capacity, allowing them to make strategies and plans almost as if they had feelings. In my research, however, what is explored and analysed in detail, rather than held as an assumption is how individual professions make strategies and plans to respond to other groups’ actions and how they arrange their own members’ demands. Since the interactionist approach, monopolists have emphasised a profession as an active and strong existence. Interactionists have assumed that members of society, often working in pressure groups and occupational associations, are actively striving to change the system of stratification to their own advantage (Larson, 1977; Berlant, 1975). In the research, I specifically examine actions and responses of the professions to make the situations favourable to themselves.

I do not concentrate on the following weak points of Abbott’s work. As Macdonald (1995: 16-17) points out, Abbott’s theory passes over professionalisation, uses a weak classification of formal variation in theories of professionalisation with

unconvincing sets of properties, and makes the ‘*procrustean*’ categories for environmental factors. However, such deficiencies in Abbott’s work do not seriously matter for my research. First, as I argued earlier, the main medical professions in Korea finished their external or formal professionalisation before the 1960s. Their qualitative development or maturation will be explained in the section on internal and external environmental forces. Next, Abbott’s classification of the former studies on professionalism is not an important point of my study. Finally, as Macdonald commented, there *were* unclear points in Abbott’s division of environmental factors. However, that classification of factors itself is not an essential point for my research. Of greater importance is identifying which factor influences jurisdictional change or conflict and how that happens, not which factor should be included in each category.

3.4.3 Theoretical Framework

The theoretical framework for the research has two levels: one is for four individual cases of medical conflicts; and the other is for the entire research.

The theoretical framework in Table 3-2 will be used for each of the four medical conflict cases.

Table 3-2 Theoretical Framework for the Individual Conflict Cases

1. Development of conflict: background & chronicles
2. Relationship between medical professions
3. Strategies of individual professions
4. Relationship of medical professions with the government and civic pressure groups
5. Other social, cultural, political and economic factors of conflict

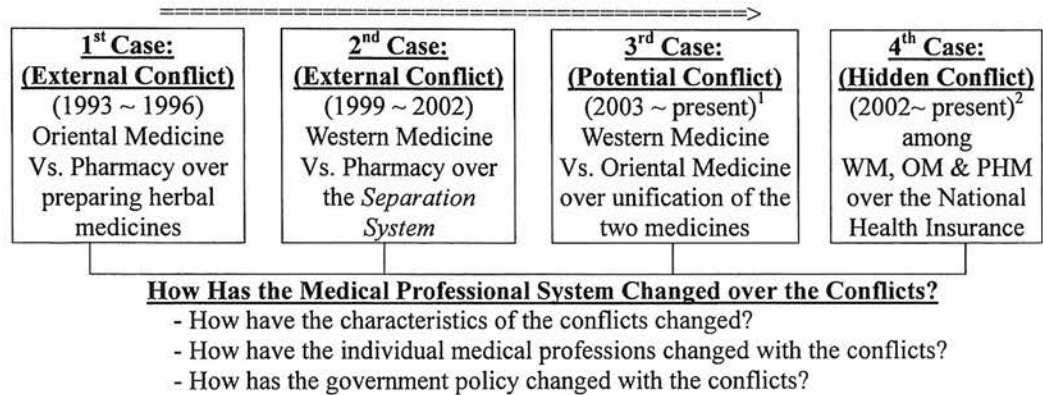
For every conflict, the development of jurisdictional conflict is presented first. Then the relationships existing between medical professions and the strategies of individual medical professions used against their counterpart and against or for the government or other groups will be shown. The role and attitude of the government and civic groups are explained, and other environmental factors are subsequently studied. The main base of the frame is the theoretical background from Abbott’s work, and complementarily, from other studies on pecuniary interests of professions. The refined concepts and characteristics of the system of medical professions in Figure 3-1 also supply a cognitive source in establishing the theoretical framework. This then becomes the basis for interview questions and the frame for data analysis.

The entire research consists of the following four cases of medical conflicts in

Korea, as shown in Figure 3-2. After examining individual cases according to Table 3-2, comparison among the four cases is presented.

The comparison among the cases shows how the medical professional system changed through the conflicts. Specifically, the comparison provides information about how individual medical professions changed with the conflicts; how the government’s policy changed with the medical conflicts; and how the characteristics of the medical conflicts themselves changed.

Figure 3-2 Theoretical Framework for the Entire Research



¹ The analysis period will be restricted to March 2003 ~ October 2003.
² The analysis period will be restricted during the year 2002, only when data for research is available.

CHAPTER 4. RESEARCH METHODOLOGY

Chapter 4 describes methodology of the study, the whole process of my research and fieldwork strategies. In order to explore further sociological characteristics of the main medical professions and the system of medical professions in Korea, a qualitative approach is used with in-depth interviewing and elite interviewing. This chapter is expected to present a few important lessons for the Korean academic field of government policies, where quantitative approaches have been dominant.

Developing topics for interviews and selecting interviewees had originally been planned based on the factors and topics in Abbott's study (1988). That plan was then revised and supplemented with a pilot survey before the fieldwork. In addition to that fieldwork preparation, how the interviewees were contacted and arranged and how the fieldwork took place are presented. The process of preparing for research, doing fieldwork and analysing data is shown with the researcher's own experiences²⁷. The evaluation of the fieldwork presents a few lessons for elite interviews in Korea. This chapter also suggests how data is analysed.

4.1 Research Method and Data Sources

My research takes the form of a case study of the medical professional system in Korea, with four specific cases of recent conflicts among medical professions. Many studies on professions, including Abbott's, have employed the case study as a research method (Abbott, 1988: 2). A case study is consistent with the purpose of describing or exploring a certain objective, here, professions and the professional system, in depth.

A qualitative approach to research with elite and in-depth interviewing was my main research method. Interviews were undertaken with elites: government officials in charge of health care policy, leaders of the three medical professions and leaders of civic voluntary groups, as well as with members of the three medical professions. Elite individuals are considered to be influential, prominent and well-informed persons in an organisation or community and are selected for interviews on the basis of their expertise in areas relevant to the research (Marshall and Rossman, 1995: 83). Valuable information was expected to be gained from interviews with these participants, who hold important positions in their areas.

²⁷ This chapter of research methodology is written in an impressionist style, as described by Maanen (1988), while the analysis part itself in the next chapter is presented in a realist style (Marshall & Rossman, 1995: 117-118).

There is an opinion that the difficulties of gaining access and establishing the rapport necessary to study elites have been exaggerated (Ostrander, 1995: 143). However, many studies acknowledge that elite interviews are more challenging than non-elite ones and have more delicate issues (Hertz & Imber, 1995: viii). Particularly, Korean society tends to be less open and more conservative than western societies. Regarding those circumstances, gaining access and penetrating the class culture enough to reveal the elites' concerns and viewpoints was expected to be still difficult.

While preparing for interviews with elites, I considered the following points: using my own personal network to contact subjects; collecting information about individual interviewees and doing preparatory background work about topics that they could mainly concern before interviews; making the right contacts in the right order, by which I would meet key persons later than others with further information; taking extra time to meet directly with people who have concerns and respond actively to those concerns while at the same time maintaining clear control of the research (Ostrander, 1995: 135); and attempting to give them trust that I would be an objective researcher.

The research was planned to pursue medical professionals' and government officials' experiences and opinions, as well as individual associations' and groups' strategies and policies, during recent medical conflicts. Research with in-depth interviews shows more clearly sensitive areas and issues, which have previously not been open. For example, how individual medical professions have contacted and persuaded the government and the political system is revealed in terms of interviews with leaders of the professions. I employed unstructured interviews aimed at discovering new and delicate material, and allowing interviewees to speak their minds and develop their ideas (Bernard, 2000: 189, 227).

In addition to interviewing, I collected data from diverse sources such as web site pages and messages from bulletin boards on the internet, newspapers and magazines, government publications and official statistics and records. Many internet sources show professionals' direct and graphic emotions, feelings and attitudes²⁸. Because medical conflicts in recent years have been among the hottest issues, I found a large number of meaningful messages from web sites. Reports in the press were also collected. Up-to-date information and concrete anecdotes in newspapers and magazines show how medical professionals contend and make settlements with each other, and which characteristics of individual groups affect their own dominance over professional jurisdictions.

²⁸ Over the last decade, Korea has been among the most frequent users of the internet in the world. According to a research of Nielsen/NetRatings Inc. in 2001, Korea is the second country for facilitating and using the internet in the world, following the US (Donga Ilbo, May 6, 2001).

I attempted to obtain some internal records of the government and medical professions. When records were on restricted access, I negotiated with those who held the data in order to persuade them to allow me the privilege of accessing the material.

4.2 Developing Topics for Interviews and Selecting Interviewees: Original Plan

For the interviews, I outlined a structure composed of sub-topics and questions mainly from Abbott's study (Abbott: 1988) as shown in Table 3-1 (p.51).

To obtain the information about those sub-topics, I planned to interview medical professionals, government officials and leaders of civic pressure groups as main subjects. Leaders of individual medical professions were also considered interviewees, because they were the best informed about the unrevealed, internal circumstances of the medical professional system. I would interview a few top managers of hospitals, who were not medical professionals, expecting them to have different opinions on the recent health care policy and conflicts among medical professions.

Since the government is the main arbitrator in mediating disputes among medical professions, I planned to interview a few government officials in the Ministry of Health and Welfare in charge of health care policy and the National Health Insurance scheme. At the same time, I intended to interview leaders of civil pressure groups, because those groups have functioned as other arbitrators among medical professions since the government lost its initiative in controlling the conflictual situations. In all, I originally planned to interview around 35 persons for the research.

Based on the subtopics in Table 3-1 (p.51), the interview questions were planned as follows. The interview would be unstructured, the followings would be categories or guidelines, not specific or required questions.

First, interviewees would be asked about personal experiences during the medical conflicts with other professions in order to show the lively and specific stories about the medical conflicts that existed behind the official and external news about them. Professionals were expected to describe their actions and feelings during conflicts with other professions. These stories would supply information about the medical professions', the government's and civic groups' organisational features and managerial capacity. Particularly, the experiences of leaders of individual groups would show their strategies and the process of their decision-making.

Second, interviewees' opinions and judgement of other professions or other players would be asked, especially, the role and position of the government and civic groups. The answers would help to understand the relationship between the medical

professions or between them and the government or civic groups. How the government managed the situations and influenced the conflicts would be revealed. How civic groups intervened and what they did would be also shown from their comments.

Third, by being asked about the existing social and general situations, interviewees would be supplying information about social, cultural and other environmental factors which would influence the medical conflicts, actions and attitudes of the main players.

4.3 Pilot Survey and Its Lessons

I pilot-tested questions presumed to be necessary for the research in order to form and develop topics for interviews. The pre-survey also had the purpose of checking the original plan for selecting interviewees. The topic of the research, conflict between medical professions, was one of the most sensitive issues in Korea. In addition, interviewees would be highly educated persons in medical professions, the government and other social groups. These circumstances required well-organised, well-planned and cautious interviews. I pre-surveyed some prospective interviewees by e-mail with open questions and on the phone.

The subjects in the pilot survey were two physicians (*WesternPhysician05*; *WesternPhysician12*), one professor in the nursing department (Park, H.), one government official (*GovernmentMember4*), one pharmacist (*Pharmacist1*) and one oriental doctor (*OrientalDoctor1*). Different questionnaire revisions were sent over two or six times respectively. Each reply was used to develop a follow-up questionnaire. From the result of the pilot survey, I obtained important lessons for the fieldwork, which helped me revise and supplement the original research plan. They were divided into the following three points: lessons for developing topics, those for selecting interviewees and those for setting up strategies for interviewing in practice.

4.3.1 Learning from the Pilot Survey for Developing Topics

Most replies from the pilot survey provided details that helped to refine topics for the interview. The interactive process of questioning and answering with a western physician, *WesternPhysician05*, on six occasions, produced a good example.

In the first e-mail to *WesternPhysician05*, I posed a series of general questions about the medical educational system and the process of becoming a general practitioner or a specialist. Because I did not expect that he could comfortably respond to questions over what he considered a sensitive issue so early in the interview, I decided to ask a number of neutral background questions first, instead of direct sensitive ones. As

expected, he sent detailed information only about the topic, without any other personal opinions on the recent hot medical issues (*WesternPhysician05's* 1st e-mail, 22/10/01).

In the second questionnaire, I asked a further question about the concept of a general practitioner and a specialist in Medical Service Act and their functions in practice. I assumed the topic would lead to a criticism of problems in medicine and health care. As expected, he criticised the government's health care policy and structural problems of health care.

I felt frustrated and sometimes humiliated, because even psychiatric specialists in clinics should attract patients such as rich women requiring diets and follow their demands in order to manage their clinics. ... I should compete with pharmacists in seeing patients with a cold, under the present circumstances, where all medical professionals competed with each other under the same condition. The responsibility for all these structural unreasonable problems lay with the government (*WesternPhysician05's* 2nd e-mail, 23/10/01).

The second interaction with a question and answer revealed that even a simple and general question about a problem could make a professional give a strong criticism and an emotive response against the existing whole health care system.

At the next step, I asked directly about the relationships among the main medical professions, western medicine, pharmacy and oriental medicine. *WesternPhysician05* only focused on the relationship with pharmacy in the answer. Strong criticism against pharmacy and the government followed.

The serious problem is that there are more pharmacies than small stores in a town. ...The present government and policies only try to kill [seriously harm] all doctors (*WesternPhysician05's* 3rd e-mail, 15/02/02).

There was no comment on oriental medicine, which suggested that the most important task for western physicians was the conflict with pharmacy.

In the fourth e-mail, I asked only about the relationship with oriental medicine, which was the issue not responded to in the previous reply. I particularly commented on a tragic part of oriental medicine history, expressing some sympathy. *WesternPhysician05* responded to the questions with only one sentence: "No need for sympathy with such a superstitious thing (*WesternPhysician05's* 4th e-mail, 17/03/02)". Instead, criticisms of pharmacy were made again. Then, blame followed toward the executives of the Korean Medical Association for their passive and lukewarm reactions. Regardless of the question about oriental medicine, the respondent focused on the conflict with pharmacy.

The fifth e-mail was, strictly speaking, not a questionnaire for a pilot survey. It

was only to reaffirm whether the residency was a four-year course for all specialties, a topic already dealt with the first e-mail. In talking about different periods of residency for different specialties in the past, the respondent talked about internal competition and division among different specialties. Then, he pointed out different fees for medical services in different specialties. He argued that this was the government's 'plot' for the purpose of breaking up the physicians' solidarity and influence (*WesternPhysician05's 5th e-mail, 27/11/02*). I realised then that even a common and neutral question would lead to a strong argument against the government and its existing health care policy.

The last questionnaire was about the process and method for deciding fees for uninsured medical services and for learning why doctors prefer uninsured rather than insured medical services. This is related to the issue of conflict among medical professions in the National Health Insurance (NHI). For the first question, *WesternPhysician05* gave only rough and brief information about how fees for uninsured services are decided. The second question focused on the controversial issue of the NHI payment system.

Why do doctors strongly recommend patients to receive uninsured services? It's partly because of the possibility of tax evasion. Most of all, the level of fees for uninsured services is proper [compared with that for insured services]. They [uninsured services] also give us a quick circulation of cash. ... Once it even took over six months for the Medical Aid Program to pay me fees for insured medical services after examining bills from my clinic (*WesternPhysician05's 6th e-mail, 30/01/03*).

To defend western physicians from blame for tax dodging, he emphasised "the absurdity of the fee system in the NHI".

To survive serious competition with colleagues and even with pharmacists [functioning as general practitioners in practice] and to survive an unreasonably low fee for insured services from the National Health Insurance, tax evasion seems, to be honest, an inevitable method for physicians. (*WesternPhysician05's 6th e-mail, 30/01/03*)

He expressed again his frustration with the government and pharmacists. His answer appeared to emphasise that there is an underlying practical and emotional conflict among medical professions over deciding the fee for medical services in the National Health Insurance.

Using the interactive process described above and interactions with other respondents in the pilot survey, I found the following points to help supplement and enrich the original interview questions.

Firstly, the respondents in western medicine and oriental medicine believe that pharmacy has caused all the problems in health care, either through seeing patients or by being paid in the market of medical services or from the National Health Insurance, and that the government is on the pharmacists' side. This meant that I needed to survey pharmacy in more detail, particularly about how pharmacists become involved in these big medical conflicts and how they strongly influence competition with oriental medicine and western medicine.

Secondly, those who replied in the pilot survey included comments about their financial difficulties when managing their clinics or pharmacies. They often indicated that "other medical professions were taking our share". Therefore, during interviews I needed to ask questions that concentrated more on the economic issues related to the medical conflicts.

Interviewing *WesternPhysician05* implied that there would be other points to be revised and supplemented when selecting interviewees and setting up strategies for interviewing. They will be shown in the next two sections.

4.3.2 Learning from the Pilot Survey for Selecting Interviewees

The pilot survey also made me reconsider the intended interviewees and change the original list.

The first change in interviewee selection came from pre-survey with a government official by e-mail and on the phone over five occasions. In the first e-mail to him, I asked about the government's policy or direction with regard to the supply of medical professionals. I asked not only general questions about the system, the policy process and the long-term plan in health care, but also the respondent's personal opinion about the influence of the medical professions involved or political relationships among them over the policy process. A detailed answer to every question came from the informant, *GovernmentMember4*.

However, at the second step, when I asked further questions about processes within the government, *GovernmentMember4* expressed difficulty and embarrassment in supplying the information. He politely, but firmly, declined to answer my direct question about a hidden process in the fee decision in the National Health Insurance.

...I'm afraid I must tell you that it would be impossible to release internal documents with regard to the decision over the fee for medical services in the National Health Insurance. ... Last year, there was a special investigation of this issue over one month by the (National) Board of Audit and Inspection. Several officials were subjected to a

disciplinary measure. ... No one could reveal the classified information and documents under the forbidden clause, which forbids government officials from disclosing secrets obtained on official duty. (*GovernmentMember4's 2nd e-mail*, 23/11/02)

Instead, *GovernmentMember4* promised to give any updated official reports and documents on the issue. Around that time, another two government officials, who were prospective interviewees, each indicated that they would not be able to give an interview. This made me sure that I could not expect much from interviews with government officials and that I might need help from other informants or sources.

In re-checking the respondent's e-mails, I found an important clue for selecting or rearranging interviewees in the government. In his first e-mail, *GovernmentMember4* answered:

... In a decision-making process, I must say that the government's influence is still stronger than that of individual medical professions. The reason is that the main body for implementing policy is, after all, the government. But, in recent years, some members of the National Assembly have increasingly tended to represent a medical profession and supported their right and benefits. So, the appearance of conflict seems to change from one between medical professions and the government into one between the National Assembly and the government (*GovernmentMember4's 1st e-mail*, 10/12/01).

To find other sources instead of government officials, who were expected to know something of the internal process of health care policy and the National Health Insurance, I decided to find members or officials of the Committee on Health and Welfare in the National Assembly. Then, I obtained confirmation for an interview from *GovernmentMember2*. An interview with him was expected to complement formal or limited information from government officials and be a more open information source.

The second idea for selecting interviewees came from the pilot survey with *WesternPhysician05*, as shown in the previous section, and with other medical professionals. The professionals, particularly the pharmacist, in the pilot survey were not familiar with the inside circumstances or the decision-making process in their associations, although they showed loyalty for and pride in their professions. It also appeared to be difficult to obtain information, from professionals in the lower rank and file, about the internal decision-making process of setting fees for services in the National Health Insurance and for other strategies or policies in individual professions. Therefore, I would need interviewees and sources at a high level in the professions who could provide internal and political information. Although leaders of professions had been

among the interviewees, interviewing them became more necessary and irreplaceable over the pilot survey.

4.3.3 Learning from the Pilot Survey for Setting up Interview Strategies

The pilot survey supplied the following clues in setting up strategies for interviewing in practice.

Firstly, the conflicts among medical professions appeared to be more serious and intense than presumed. Reactions against other professions were emotional and strong, implying other issues. Under the circumstances, if respondents felt comfortable with the researcher, or felt that the researcher was not their “enemy”, they would straightforwardly express their opinions or emotions. Therefore, I should show interviewees that I could be on their side or, at least, not be their “enemy”.

Secondly, I would also need to consider each respondent’s position, gender and career. For example, *WesternPhysician05* was an acquaintance of the researcher, which might be why he could easily and comfortably supply his frank opinions in detail. I would encounter less open (more defensive) interviewees in practice. This point I should bear in mind in interviewing. In addition, respondents in the lower rank and file of associations appeared to be more open and direct in expressing their opinions, while leaders of medical professions were likely to respond in a different way, presumably less emotional and more political.

Thirdly, once an issue emerged, even the researcher’s brief comment on or question about health care led one respondent actively to present further personal arguments about intricate problems. Even a neutral or apparently trivial comment from the researcher can arise strong feelings in the respondent and encourage him/her to give further and strong opinions. This implies that an interview can progress rapidly at a certain point. With that in mind, I now concentrate more on interviewing in order not to miss any clue, which could be used as a prompt for further questioning.

4.4 Contacting and Arranging Interviewees & Other Preparation for the Fieldwork

Accessing interviewees was one of the most difficult tasks in the research. Likewise, contacting medical professionals and high government officials involved considerable time and cost.

To contact planned interviewees, I used a formal request for cooperation by mail, including a stamped, self-addressed envelope. In the formal letter, I supplied the purpose of the research and topics of the interview, clarifying that the interview would be used only for academic purposes. I also promised confidentiality for the interview, stating that an interviewee's personal details would be specified on the thesis only with his/her permission. Calls and e-mails were also used for confirmation.

By 31 January 2003, just before the fieldwork, I had selected 41 persons and contacted 33 among them. To contact western physicians, oriental doctors and pharmacists in the lower rank and file in individual professions, I used my own personal network. By e-mail or on the phone, I briefly explained my research and then asked permission to interview them. Afterwards, I sent a formal letter of request. In order to select leaders of individual professional associations as interviewees, I searched the website of every medical association. Then I looked for a person responsible for Public Relations or Planning Policy in every association or an influential group in medical professions. I decided to contact 7 leaders on arriving in Korea for the fieldwork, because under Korean traditional and Confucian circumstances, persons in high positions would not be happy being contacted by a stranger on the phone or by mail alone. Among the 33 persons asked for interview, 22 confirmed that they would be willing to cooperate²⁹.

Part of my fieldwork preparation was to secure letters of introduction from my academic supervisor and assistant supervisor. I would use them when contacting leaders of medical professions and high government officials. They were expected to be effective, because a formal document or letter would work well in Korean society.

When recording interviews, I relied on audio tape-recording backed up by written field notes. Field notes provided other relevant information about the context of the location, the climate and atmosphere under which the interview would be conducted, clues about the interviewees' intents and feelings behind the statements and comments on aspects of non-verbal communication (Denscombe, 1988: 122).

4.5 Fieldwork in South Korea

The fieldwork in South Korea brought unexpected and very positive outcomes. I gathered substantial high quality data from diverse sources that included key leaders of every medical profession and influential figures in other groups. The data showed internal and

²⁹ They were 7 physicians, 5 oriental medicine doctor, 5 pharmacists, 2 government officials, 2 leaders of civil pressure groups and 1 manager of a general hospital. Among the 11 negative responses, 6 did not give me a response, 2 declined to be interviewed and 3, whom I contacted later on the phone, reserved their confirmation. The official reason for their negative answers was their "busy schedule". One of them was to be abroad during the time of my fieldwork.

unrevealed processes in the medical professional system. Even though I had to change interviewees during the fieldwork mainly because of limited time and cost, the general outcome of the fieldwork has been successful.

Table 4-1 summarises the outcomes of the fieldwork. The specific processes and results of the fieldwork will follow.

Table 4-1 Summary of the Fieldwork

- Period: 10 February to 26 April 2003 (76 days)
- Regions: Seoul (for 26 interviewees) and other cities (for 10 in Daegu, Daejun, Ulsan and Changwon) in South Korea
- Arranging and Interviewing: contacting 62 persons (41 before the fieldwork in Edinburgh) and interviewing 36 persons over 39 occasions
- Interviewees: 14 physicians (including 6 key leaders), 5 oriental doctors (including 3 key leaders), 5 pharmacists (including 2 key leaders), 4 government officials, 4 civil pressure group leaders, 2 hospital managers and 2 journalists
- Hours of Interviewing: 58 hours and 20 minutes in total, 1 hour and 31 minutes per interview (on the average)
- Places of Interviewing: 22 occasions in offices or meeting rooms, 12 in restaurants and 5 in coffee shops
- Post-interview Responses: from 8 interviewees over 14 occasions (June to November 2003)
- Other Data than Interviews: internal documents and minutes of the meetings of the government and the medical professions

4.5.1 Changing Interviewees

I had to change the planned interviewees during my fieldwork. 8 prearranged persons changed their mind and cancelled or asked me to “postpone” their interview. The main reason given was their “busy schedule”, but they appeared to feel burdened by having to comment on sensitive issues. I discarded 10 interviewees and instead, contacted 21 new persons during the fieldwork. My main reason for changing them was discovering that I actually reached key leaders of the medical professions, something I had not expected. They were not simply official leaders, but the main figures in their associations, who had devised all policies and whose influence had been an essential factor in gaining the vote for president of their professions. Therefore, in order to interview these key leaders, it was necessary for me to change the existing plan.

Another reason why the interviewees had to be changed was learning that the roles of civil pressure groups and the press were more important in deciding and enforcing health care policy than I had anticipated. Before starting the fieldwork I had

arranged to interview three leaders of those groups. However, they came from academic backgrounds and were less known in political and practical circumstances. Although they had official positions as leaders, they had not been active or direct players during the medical conflicts. During the fieldwork, however, I reached the true leaders of civic groups, who had been directly involved in the medical conflict as arbitrators and leaders of actions.

In order to interview newly contacted influential persons and manage my work with limited time and funds, I needed to cancel a few prearranged interviews with those practising and managing their own clinic or pharmacy in small cities or big cities other than Seoul. In some cases, I cancelled the appointment by not following up when those approached were not active in accepting their interviews. However, in a few cases, I had to send a carefully worded letter of apology to cancel appointments. Table 4-2 shows changing interviewees from the plan to the fieldwork in practice.

Table 4-2 Changing Interviewees Before and During the Fieldwork (unit: person)

	Final Interviewees (A+B) (C+D)	Planned before the Fieldwork ²	Contacted & Arranged before the Fieldwork ³ (A)	Newly Contacted during the Fieldwork (B)	Cancelled by Interviewees during the Fieldwork (C)	Cancelled by me during the Fieldwork (D)
Total	36	41	33	21	8	10
Western Physicians	14 (6) ¹	10	9	9	2	2
Oriental Doctors	5 (3) ¹	10	8	2	2	3
Pharmacists	5 (2) ¹	10	8	2	1	4
Government Officials	4	7	4	2	2	-
Civil Group Leaders	4 (3)	3	3	3	1	1
Hospital Managers	2	1	1	1	-	-
Journalists	2	-	-	2	-	-

¹ figures in parentheses: the number of executives from individual associations & civic groups

² (A) + persons who declined interviews and did not respond

³ Including persons who accepted interviews and suspended their confirmation

4.5.2 Interviewing in Practice and Collecting Other Data

It took 58 hours and 20 minutes to interview 36 persons over 39 occasions as shown in Appendix I. The average time was one-and-a-half hours. The interviewees from oriental medicine and civic pressure groups allowed me the longest time, one hour and 45 minutes on average. However, those working in a bureaucratic organisation, namely, government

officials and managers in hospitals, gave me the shortest time, about one hour. The executives in individual associations permitted me to interview them for the longest time, explaining the conflictual situations and their own positions for 3 to 4 hours. It also took longer to interview persons who were arranged through my own personal network. The interviews that were arranged using the *snow-balling* method in the lower rank and file of individual associations took no more than an hour.

Regions and places for interviews are shown in Appendix II. 26 interviewees among 36 were in Seoul. 22 of the 39 interviews occurred in the interviewees' office or meeting room.

The interviews were done roughly in the following order:

- (1) western physicians, oriental doctors and pharmacists in the lower rank and file
- (2) leaders of oriental medicine, pharmacy and civic groups; journalists;
western physicians in the lower rank and file; and managers of hospitals;
- (3) government officials; and leaders of western medicine.

The order was formed not by my own plan but by the interviewees' acceptance and schedule, which I had to follow. As shown in the order, contacting and interviewing government officials, and particularly, the key leaders of western medicine, was the most difficult task during the fieldwork³⁰. In order to approach the core of western medicine, I searched for opinion leaders of western medicine on the internet, who did not have official positions in the association but had a strong influence on western physicians. I contacted one of the strongest opinion leaders, *WesternPhysician13*. Finishing the interview with him, I asked him to help me meet a key leader in the association. He arranged for me to meet two key leaders in the Korean Medical Association. At that time, in mid-March, there was to be a direct presidential election within the KMA, and the candidates, including the then president and the former president, could not ignore *WesternPhysician13*'s influence.

Among interviewees, there were figures as important as key leaders in the medical associations or high government officials. They were well informed about the internal process and circumstances of individual medical professions and the government, or they had played a key role during the medical conflicts. At the time of interviewing,

³⁰ Interviewing key leaders in the oriental medical association and the pharmaceutical association was, comparatively, not difficult. The process of arranging and contacting them was not very complicated, and they welcomed the interviews. One reason for their friendly attitude might be that those professions are weaker than western medicine and they need and pursue support from as many as possible from diverse groups. These two associations tend to be open to someone from outside their professional groups.

they were not working as medical professionals, but their then occupations had been still based on their previous medical profession.

For example, I interviewed a person, who has a licence in a medical profession, graduating from one of the best universities in Korea. During the conflict between western medicine and pharmacy over the separation system, he was a key government official. It was he who devised the separation scheme and played a key role in enforcing it. He does not deny that he was on the side of one profession at the time he was doing his work. He is said to be one of “the Three Cleverest Men” in the government. However, the opposition profession calls him one of “the Five Enemies”³¹, who destroyed them by enforcing the separation system. As the conflict erupted, he resigned from his post in the government.

The second example is interviewing an influential journalist in health care. He also has a licence in a medical profession. He is one of a few people who have an objective perspective on medical policy in Korea. Other interviewees, including those even from other professions, identified him as a reliable commentator (*Journalist2*; *Pharmacist4*). Considering that Korean medical policy has been strongly criticised by the different medical professions, his role and comments in the press are prominent.

The last example is an interview with a person, who came from a medical profession and now has a high position in a national institution. He once owned and ran a medical facility. As a government official, his role is to establish long- and mid-term plans for the development of health care and to make reports for the government. During the interview, he emphasised that he did not work for a certain medical profession but for the government, from an objective perspective. He also insisted that he was no longer a medical professional, even though he still has a licence. His case, which emphasises his role as a government official or researcher, is contrasted to the first example above, who does not hide the act that he was on the side of his profession while he worked in the government.

In the meantime, I obtained important data other than from interviews and documents, records or white books from individual medical associations. I was able to access to internal documents of the National Health Insurance for a limited time only at a certain office. The decision-making process in a certain health insurance policy is a closed one and only the results are open. Therefore, it was the internal Committee documents that supplied information about the further and true relationships between medical professions.

The full record of an emergency meeting of leaders of oriental medicine is

³¹ It is a parody of the *Five Betrayals* of Korea to the Japanese Government in 1905.

another important data. Facing a conflict with western medicine over the issue of *IMS & Needle TENS* in March of 2003, the oriental medical association called an emergency meeting, and I was allowed to attend it as an observer. The record of the meeting showed characteristics of the oriental medical association, attitudes of oriental doctors to other medical professions and their pending issues.

After the fieldwork, some of the interviewees gave me recent and supplementary information. Post-interview information or comments came from 8 interviewees over 18 occasions (*WesternPhysician05* and *WesternPhysician11* in western medicine; *OrientalDoctor1* and *OrientalDoctor4* in oriental medicine; *Pharmacist3* and *Pharmacist1* in pharmacy; *Journalist1* in the press; *GovernmentMember4* in the government).

4.5.3 Evaluation of the Fieldwork

As presented above, I obtained high quality information through the fieldwork, which had not been revealed before. The interviewees' comments and other important data show what happened inside the medical professional system and the government during the medical conflicts, why the conflicts happened, and how the professions were involved and the government reacted to the conflicts.

As the interviews continued, the topics and contents of the interviews became more specific and revealed the core of decision-making processes and circumstances within the medical professional system. Information from previous interviews was fully used to draw out more information in the next interview. Those persons who were difficult to contact and considered more important were scheduled for the later part of fieldwork. When I finally met them, I had already obtained considerable important inside information and could handle those interviews well.

It is difficult to compare the processes used in my fieldwork, particularly those of interviewing elites, with those in other studies in Korea, because there have been few studies using elite interviews as the main research method and way of presenting the interview processes. Nevertheless, the following lessons from the fieldwork can be learned by considering elite interviews in western countries (Ostrander, 1995; Gamson, 1995; Becker, 1995).

Most of all, the competitive situation in Korean health care, with its serious conflicts between western physicians, oriental doctors and pharmacists, favoured the fieldwork. Individual professions were attempting to appeal their situations, using their own justifications and requiring more supporters. Under the circumstances, I was often considered a potential supporter. At the same time, I needed a neutral and objective

attitude in order to contact and interview persons from different professions. When they had any doubt about my position, “an academic purpose” and “studying abroad” covered it. It was still difficult to find a path to the core of western medicine, which is considered a dominant power in the system of medical professions. Compared with those in other medical professions, key leaders in western medicine were not positive about granting interviews. However, once accepting me as a trustable researcher, they presented their opinions more honestly and actively than any elites in the other professions.

Secondly, important interviews with key leaders were arranged only during the fieldwork. The most effective way to contact key leaders and arrange interviews with them was to wait for them in or outside their offices. Calling phones and sending e-mails or letters seldom worked. Other active attitudes in contacting and arranging meetings appeared to be effective. I showed full respect for their work by attending their lectures or other meetings. The interviewees then attempted to help me by introducing me to others or by furnishing information on the topic.

Thirdly, the fact that I had already interviewed other important persons, not only in the same group, but also in the opposition group, became a credit in accessing the next prospective interviewees. Even though key persons in the medical professions and other concerned groups faced each other in the conflicts, they knew each other very well and most of them highly valued the others’ political and managerial capacities. Therefore, their colleagues’ introduction, along with their own information or my own statement that I had met other important figures, encouraged prospective interviewees to allow the interviews.

Fourth, responses from incumbent government officials were less active and more cautious than those from other interviewees. Even after accepting an interview, they were reluctant to undertake it. They never allowed more than an hour for their interviews. However, former government officials or persons in the political field were more active in responding interviews.

Fifth, developing research topics and other preparatory work with the pilot survey were useful in contacting interviewees and interviewing them. The references from my supervisors also gave interviewees a strong impression that my work was “well-prepared and trustworthy (*WesternPhysician13*)”. My own status and academic career, a PhD studying health care policy in the UK, also appealed to the interviewees. All those helped the elites trust the researcher and the study.

4.6 Analysing Data

In analysing the data, I mainly used the theoretical framework from Abbott’s theory,

though revised by the pilot survey, and the categories of interview questions drawn from that theoretical framework. I did not use a software program, because the study did not require an advanced level of analysis, such as modelling or theorising. What I wanted to know in terms of the research and data analysis was what happened in the Korean medical professional system and which factors influenced jurisdictional conflict and the professional system. Analysis skills needed for the study were how to sort and arrange data and then how to categorise them. Based on the theoretical framework and the pilot survey, I judged that the contents of transcripts could be sorted, classified and categorised well only by editing them in a word program.

As Glaser and Strauss (1967) comment, the most fundamental and difficult operation in the analysis of qualitative data from interviews is that of discovering significant classes of things, persons and events, along with the properties which would characterise them. Until a frame for data analysis was fixed, there were complicated, repeated and overlapping processes, which needed to amend and refine the existing theoretical frame. The following processes will show how the frame for data analysis was made and how all data were analysed. The processes are consistent with the analytic procedures that Marshall & Rossman (1995: 113-118) suggest.

As the first step for data analysis, I typed all the scripts from the voice files. Then, I graded the individual scripts by interviewees into 4 groups according to their quality and importance. The first grade of the scripts was composed of the most prominent interviews from every group, which could tell the inside situations and decision-making processes. After considerable reading, I made paragraphs in every script by segmenting a long story. The notes during interviewing were a great help in this process. At the end of every paragraph, the interviewee's name was marked.

Secondly, the category generation phase of data analysis was the most difficult, complex and ambiguous of all the processes in the data analysis, as Marshall & Rossman (1995: 114) stated. Reading the first-grade scripts repeatedly, I sorted the main points to make a frame for the study. These points were compared with subtopics in the theoretical background shown in Table 3-1 (p.51). Then, the first structure for data analysis was formed by individual players, a comparatively easy method to classify data. As shown in the following pre-frame, Table 4-3, I made the large categories by using individual players, such as medical professions in conflict, the government, civic groups and others. Every medical profession had properties, which the theoretical background provided.

According to the pre-frame in Table 4-3, I arranged the first-grade scripts by allocating every paragraph of scripts to a certain category, one by one. The work required high concentration on the points in the frame and the contents of the scripts at the same

time.

Table 4-3 Pre-frame for Data Analysis from the First-grade Interview Data

1. Profession <i>A</i> in conflict	
1) Organisational Features	2) Professional Knowledge & Technology
3) Professional, Economic & Political Attitude	4) Political Capacity & Influence
2. Profession <i>B</i> in conflict	
1) Organisational Features	2) Professional Knowledge & Technology
3) Professional, Economic & Political Attitude	4) Political Capacity & Influence
3. Role & Attitude of the Government	
4. Role & Attitude of the Civic Groups	
5. Public Opinion & Other Social and Cultural Circumstances	
6. Interim Conclusion	

Thirdly, the first data analysis in the previous step, which was based on the pre-frame in Table 4-3, had a critical weak point in that it focused too much on characteristics of individual professions. It overlooked the relationships among the professions and the interaction between the system of the medical professions and its environment. The original scripts showed that the pilot analysis might have underestimated the dynamics of the situations. This evaluation was a result of supervision sessions, and showed that the pre-frame for data analysis needed to be revised again.

After attempting different frames several times, I decided to focus on the fundamental issues, likely causes of the conflict or the different perspectives of the conflict, and raise them as the main sub-topics. Table 4-4 is the final frame of data analysis. In the final frame for data analysis, the fragmented points in individual medical professions in the previous frame came together. Then the interaction between the professions became more highlighted than in the previous frame.

Table 4-4 Framework for Data Analysis

1. Background and Development of a Conflict
2. Different Motivations or Perspectives of the Conflict
1) Conflict from the Professional Perspective (professional knowledge & technology, training system or values and morality from Abbott's internal and cultural factors)
2) Conflict from the Practical or Financial Perspective (from other theories)
3) Conflict from the Political Perspective (Social movements & political capacity of professions from Abbott's social and internal factors)
3. Organisational Features and Capacity of Individual Professions in Conflict (from Abbott's internal factors)
4. Role and Attitude of the Government (from Abbott's social factors & other theories)
5. Role of Civic Groups, the Public Opinion & Other Environmental Factors (from Abbott's social factors)
6. Interpretation of the Conflict

As shown in Table 4-4, for every case of the medical conflicts, different motivations or perspectives are examined first. Then, organisational features and the

capacity of individual medical professions in conflict are analysed based on a part of Abbott's internal factors. Analysing the role and attitude of the government and civic pressure groups shows how they intervene in and regulate a conflict. In an interpretation of conflict, the influence of a medical conflict on the medical professional system and vice versa is shown.

In terms of the framework for data analysis above, other interview scripts and other data are analysed. While analysing the data from lower-grade interviews, the former analysis of the first-grade data and the structure for data analysis have been refined and tuned. Then, according to the items in the frame for data analysis in Table 4-4, I have examined four cases in Chapter 5 to 8, finally showing how the medical conflicts and the system of medical professions have changed.

In the mean time, interviewees' identities are concealed while presenting their statements, because most interviews were undertaken on the premise of confidentiality. Every interviewee has own number with a code presenting one's occupation as follows³².

- *WesternPhysician(Nr.)* for a western physician
- *OrientalDoctor(Nr.)* for a oriental doctor
- *Pharmacist(Nr.)* for a pharmacist
- *GovernmentMember(Nr.)* for a government official or a political member
- *CivicGroupLeader(Nr.)* for a leader of a civic pressure group
- *Journalist(Nr.)* for a journalist
- *HospitalManager(Nr.)* for a manager of a general hospital

³² The list with all the interviewees' specific identities was submitted only to the examiners and the supervisors of this thesis.

CHAPTER 5. CONFLICT BETWEEN ORIENTAL MEDICINE AND PHARMACY OVER PREPARING HERBAL MEDICINES

In this chapter, I discuss and analyse the first open professional conflict in Korea, which occurred between oriental medicine and pharmacy during 1993~1996. Following the process in which the conflict developed, its causes from the different perspectives are presented. By analysing the conflict from the perspectives of professional knowledge and legitimacy and of economic benefits, I have attempted to trace its fundamental causes and characteristics.

This case became the starting point of the open conflictual situation in health care and the first professional conflict in Korean society. Therefore, it had important meanings not only for the two professions in conflict, but also for the whole medical professional system, health care and Korean society. The two professions' managerial and political capacities and attitudes, the government's role and attitude and the role of civil pressure group present are analysed from this perspective.

All these discussions are undertaken with regard to whether and how environmental factors which Abbott (1988) suggested influenced the conflict.

5.1 Development of the Conflict

In 1993, there emerged the first major conflict between medical professions in Korea. It was between oriental doctors and pharmacists over prescribing and preparing oriental medicines. The provision prohibiting pharmacists from dispensing and selling oriental medicines in the Enforcement Regulation of the Pharmaceutical Act was deleted by the Ministry of Health and Welfare. At that time, offices charged with medical and pharmaceutical cases in the Ministry of Health and Welfare largely consisted of former pharmacists³³. In fact, there was no institution in full charge of oriental medical issues in the Ministry of Health and Welfare. A leader of the Association of Korean Oriental Medicine, *OrientalDoctor4*, gave a specific account of the start of the conflict.

In January 1993, Choi, a government official, drafted a plan. The draft was about deleting a provision of the Medical Service Act, which prohibited pharmacists from having a chest to store oriental medicines in their pharmacy. It then passed in the Ministry of Health and Welfare. Only a few people noticed the government's decision and its implications. Dr. Seo, an oriental doctor, realised it and wrote to a newspaper protesting against the revised Enforcement Regulation. "Pharmacists

³³ The then Minister Ahn confessed a few years later that he approved the revision, because he was deceived by his subordinates (Kim, J., 1996).

invaded our monopolistic jurisdiction, preparing oriental medicines!” He and other oriental doctors, who realised the seriousness of the case, began to press the Association of Korean Oriental Medicine and its president Dr. Ahn. Meanwhile, pharmacists reacted to Dr. Seo’s article by putting an advertisement in newspapers. Pharmacists argued that oriental medicines were, after all, the same as other medicines and that they were qualified to prepare them. Oriental doctors and oriental medical students from all over the country rapidly rose up against pharmacists (*OrientalDoctor4*).

OrientalDoctor4’s quote illustrates that there had been few preliminary debates on the issue between the two professions. At the same time, there was no advance preparation of oriental doctors for the issue. During oriental doctors’ interview, they often talked of the ‘pharmacists’ attack’ or ‘pharmacists’ invasion’ as the revision of Enforcement Regulation. This showed the oriental doctors’ belief that conflict between the two professions resulted from pharmacists, who had had support in the Ministry of Health and Welfare.

With the government’s decision, oriental doctors and students protested against it and the pharmacists’ challenge to their traditional jurisdiction. In 1994, a compromise was suggested. It was to create a new medical profession - oriental pharmacy. In addition, pharmacists were considered qualified to apply for an examination to prepare specified oriental medicines. At first, the number of potential applicants for that examination had been estimated at about 2,000 pharmacists who already prepared the oriental herbal medicines, but in the following year, the true number of applicants turned out to be about 25,000 (Kim, J., 1996). The examination validity period for pharmacists was limited to two years. Debates and demonstrations over details³⁴ of the qualifying examination for pharmacists continued between the two professions. In 1995, the government announced that new departments of oriental pharmacy would be established in pharmaceutical colleges, not in oriental medical college, in specific universities where oriental medical colleges were already established. This announcement provoked serious protests again from oriental medicine.

In February 1996, 49 pharmacists took the first qualifying examination to prepare oriental medicines and 37 examinees passed the test. At the second examination in May, 23,355 pharmacists passed the qualifying examination and recorded a ratio of 97% of the successful applicants. At that time, only professors in pharmacy prepared the examination questions. Oriental doctors and students demonstrated again, because more pharmacists

³⁴ Main issues were followings: what and how many kinds of oriental medicines would be allowed for pharmacists?; what style of examination questions would be used?; and who would prepare examination questions?

than oriental doctors were to enter the market of preparing oriental medicines³⁵. In order to quieten the anger of the oriental doctors, the government announced the Comprehensive Measures for Development of Oriental Medicine, which attempted to satisfy oriental medical demands. In June 1996, the Board of Audit and Inspection of Korea claimed that there had been blunders with the second and third qualifying examinations for pharmacists. However, successful candidates of the two examinations were still authorised to obtain their licences, causing another vigorous demonstration and strike from oriental doctors. In 1997, the government announced the Plan of Development for Oriental Medicine and established the Oriental Medicine Bureau in the Ministry of Health and Welfare. As a result, the external conflict between oriental medicine and pharmacy came to an end.

5.2 Different Motivations and Perspectives of the Conflict

5.2.1 Conflict over Professional Knowledge and Legitimacy

5.2.1.1 Jurisdictional Conflict and Professional Knowledge

The conflict between oriental medicine and pharmacy was one over a professional jurisdiction, preparing oriental medicines. Traditionally and legally that had been oriental doctors' sole right until the controversial provision was deleted by the Ministry of Health and Welfare. Over the jurisdiction, the two professions faced each other as the defender and the attacker separately. In claiming sole jurisdiction, both professions employed their own professional knowledge and bases.

Pharmacists insisted that oriental medicines were, after all, a part of medicines. According to pharmacists, because they were professionals of medicines, they could and should prepare oriental medicines. Pharmacists emphasised their strong points, 'a scientific approach with high technological methods and equipment' in preparing medicines, which would be the weakest point for oriental medicine. All interviewed pharmacists argued that they were and should be the only professionals in preparing all kinds of medicines, either western medicines or oriental medicines.

However, oriental doctors never accepted pharmacists' argument that they were qualified to prepare oriental medicines. Oriental doctors considered the pharmacists' attempt to be a serious threat. In order to confront pharmacy, oriental medical professionals emphasised characteristics of oriental medicine, particularly, its holistic practice. According to the principle of oriental medicine, diagnosing, treating and preparing medicines could not be separated from each other. However, their academic

³⁵ At that time, the number of oriental doctors was 9,299.

and logical arguments did not develop any more in the conflict. Instead, oriental medicine appealed to the public with their traditional and nationalistic features. A few oriental doctors regretted this.

We should have defended ourselves against pharmacists with our fundamental academic features. We should have more strongly emphasised our characteristics and philosophy, which pharmacists could not imitate. However, we were implicated in the pharmacists' strategy. And.. people only believed that the conflict was a fight over a pie (*OrientalDoctor2*).

In fact, a 'weak system' of professional practice and less-understood professional knowledge of oriental medicine was the target of pharmacists during the conflict.

As a result of the conflict, pharmacists obtained the right to prepare 100 specific kinds of oriental medicines. From the perspective of jurisdictional conflict, pharmacists had gained. Although pharmacists were restrained in the scope of oriental medicines they could prepare, the system still gave pharmacists access to "all" oriental medicines.

Even if pharmacists can prepare only 100 oriental medicines, who would and could check and monitor them? (*OrientalDoctor2*)

They also worried that pharmacists could practise oriental medicine in the same way as oriental doctors did.

For oriental doctors, hearing a patient's voice, watching him/her, touching and feeling his/her pulse etc. all could be methods of practising medicine with patients. Who would prohibit pharmacists from practising medicine in that way? (*OrientalDoctor2*)

Whether that would happen or not, the important thing was that oriental doctors lost their monopoly in preparing oriental medicines to a strong competitor. It was judged a loss of professional image rather than of economic benefit. Indeed, pharmacists succeeded in expanding their professional jurisdiction into a different profession by stepping into oriental medicine.

5.2.1.2 Oriental Pharmacy: Dividing Holistic Oriental Medicine?

Another important professional point during the conflict was the different attitudes and opinions two professions showed toward the new profession, Oriental Pharmacy, which had been one of the most important outcomes of conflict between oriental doctors and pharmacists. Now those who graduate from newly established departments of oriental

pharmacy with a four-year course in two universities and from oriental medical colleges can apply for the qualifying examination to prepare oriental medicines.

The oriental doctors among the interviewees were sceptical about the usefulness of the new profession. The first reason came from their professional logic. As presented in the section of professional knowledge of oriental medicine (pp.15-17), oriental doctors argue that oriental medicine cannot be divided into treatment and medicines. Nevertheless,

... Oriental medicine was pushed to split, based on the logic of western medicine (*OrientalDoctor4*).

Although oriental doctors had agreed on the system of oriental pharmacy in order to break through the state of confusion from conflict, they argued that creating oriental pharmacy was not a good idea.

Actually, the newly established system, oriental pharmacy, is useless. It was a temporary expedient and unfortunately, born in the process of negotiation. It's a baby, whose parents were not known. It belonged to neither this side, nor the other. ... Dividing the functions of oriental medicine? Nonsense! (*OrientalDoctor4*)

It was our last choice. We didn't want to share our rights with pharmacists. Let's make a new one [oriental pharmacy] and give them a part of ours rather than pharmacy! That's our decision. (*OrientalDoctor1*)

Oriental doctors also directed the point that, "in practice, there is no place oriental pharmacists could enter (*OrientalDoctor1*)". Existing and new oriental doctors already had control of the market in oriental medicines. Under this situation, most oriental pharmacists, who have only graduated from their newly established department and passed the qualifying examination since 2001, have entered graduate schools.

On the contrary, the pharmacists' viewpoint on oriental pharmacy was favourable. Pharmacists welcomed the new profession.

What a smart and, and gorgeous system! Preparing all medicines, either oriental or western! It was a tremendous idea, although there would be a slightly difficulty in practice. (*GovernmentMember3*)

The interviewed pharmacists appeared to be satisfied to have succeeded in making a new profession according to their logic, that is, separation of prescribing and preparing medicines. According to the pharmacists' argument, they won the debate by

logic. The pharmacists' logic of separation was to be the basis of the separation system in western medicine, which would provoke another medical conflict later.

Pharmacists have continually attempted to win oriental pharmacy over to their side. By placing the department of oriental pharmacy in the pharmaceutical college, students in oriental pharmacy appear more linked to pharmacy than to oriental medicine. Based on messages on the bulletin board of KyungHee University, which has one of the best oriental medical and pharmaceutical colleges, the students in the department of oriental pharmacy appeared to sympathise more with pharmacy than with oriental medicine.

As shown above, the birth of oriental pharmacy was against the fundamental professional knowledge of oriental medicine. In addition, after creating it, pharmacy actively attempted to attract students in the department of oriental pharmacy to their side. Therefore, with regard to oriental pharmacy, oriental medicine appears to have lost in a professional, as well as a practical, sense.

5.2.1.3 Strategy to Reinforce Professionalism

During the conflict, oriental medicine and pharmacy realised that they would be required to reinforce their own professionalism. Pharmacy obtained a promise from the government that pharmaceutical colleges would have a 6-year curriculum, as in oriental medicine and in western medicine. Pharmacists would be expected to overcome their professional position which was weaker and lower than western physicians and oriental doctors and to heighten their social position through the new training system.

Other medical professions seriously opposed this new pharmaceutical college system: oriental doctors and western physicians commented that it would be a *national waste*.

Pharmacists' attempt [to make a pharmaceutical college with a six-year course] should be blocked in every way. Not at a strategic level but at a fundamental and practical level, it should be stopped at all costs. Pharmacists have an inferiority complex for not being 'true' medical professionals. They try to cover their weak point by expanding the term of study. .. They will attempt to invade us again. (*OrientalDoctor4*)

Western physicians and oriental doctors knew that the new training system for pharmacists would strengthen the influence and right of pharmacy. They did not want to see their competitor become stronger in health care.

After the conflict with pharmacy, oriental doctors also attempted to strengthen their professionalism. One prominent way was introducing the speciality system. Another

was attempting to use medical equipment and diagnostic methods in western medicine. However, both are difficult for oriental doctors. The speciality system faces serious internal conflict in oriental medicine (pp.15-16), and using medical equipment and methods in western medicine meets with strong opposition from western physicians (Woo, 2003; Kim, T.H., 2003).

As shown above, the conflict between oriental medicine and pharmacy over the issue of prescribing and preparing herbal medicines was a typical jurisdictional conflict, as suggested by Abbott (1988). Oriental doctors argued for their monopolistic right to prepare all herbal medicines. From the perspective of pharmacists, this jurisdiction belonged to pharmacists, because oriental medicines were a type of medicines. However, from the oriental doctors' perspective, it was impossible to divide the holistic function and practice of oriental medicine into the separate activities of seeing patients and preparing medicines.

The jurisdictional conflict between oriental medicine and pharmacy basically reflected their different professional knowledge and legitimacy. While oriental doctors argued for the traditional holistic features of oriental medicine, pharmacy approached the issue from the perspective of western medicine, which emphasises division of functions and scientisation. Oriental doctors possessed a professional pride and feelings of superiority over pharmacists. These situations reveal that Abbott's cultural factors, including professional knowledge and legitimacy, are also important ones in the first Korean case.

With the conflict, both professions attempted to reinforce their professionalism by lengthening the training periods and introducing a speciality system. These situations are examined with regard to another of Abbott's cultural factors, the emergence or role of the modern university. In Abbott's analysis, modern universities and a professional training system play important roles, particularly in the early stages of professionalisation. The Korean case shows that, even after professionalisation, a training system, particularly with the form and length of a training course, is an important issue and factor that influences professional competition.

5.2.2 Conflict over Economic Benefits

It cannot be denied that there was an economic reason for the conflict. The interviewees' comments show it. Pharmacists had an economic background in their attack on oriental medicine, and oriental doctors were sensitive to that fact.

First of all, pharmacists were having financial difficulties in managing their pharmacies. The number of pharmacists and their influence has grown over the last 30

years. Functioning as “small doctors” had allowed pharmacists considerable profits and the image of being like a doctor. However, a rapid increase in the number of western physicians and the expansion of the National Health Insurance have caused pharmacists’ financial and professional difficulties. Under these situations, pharmacists needed to expand their market into oriental medicine.

Even until the 1970s, you can recognise in old newspapers and articles,... pharmacists had argued that oriental medicines did not have any efficacy. But then, their argument changed - ‘oriental medicines belonged to medicines and we, pharmacists, could also prepare them’. Why? Pharmacists needed a new market of medicines to relieve their financial pressure (*OrientalDoctor1*).

Pharmacists argued that they could supply oriental medicines at lower prices by using modern equipment and industrial facilities. This point was a threat to oriental medicine, because supplying oriental medicines at a lower price would increase the demand of oriental medicines to pharmacies. In fact, all the pharmacists interviewed admitted that pharmacies in rural areas and small pharmacies in cities gained considerable benefits from preparing oriental medicines.

Oriental doctors also had an economic reason. One interviewee admitted that in the Korean medical system, the first matter for them was to earn enough money to manage their medical facilities. They thought that it was inevitable ‘to survive’ in a capitalistic market system.

Opening an oriental medical clinic is, as for western physicians, really a tough and dangerous thing for individual oriental doctors. To put it bluntly, without getting married to a rich girl, a doctor opening his clinic would suffer debts for several years. People will blame us for being thieves, sort of, but... We have to live first, don’t you think so? Recently, there have continually been disturbances and conflict between medical professions and the government. In every conflict, every profession argues ‘health care policy for the people’. Sounds good. But behind the catch phrase, you know, there must be complicated economic interests between fighters (*OrientalDoctor4*).

A key leader in oriental medicine, *OrientalDoctor4*, explained with specific financial data how seriously oriental doctors suffer financial difficulties in managing their clinics. In his account, he commented on the size of the non-insured part of oriental medicine.

According to an internal data of the Association of Korean Oriental Medicine and the government, the non-insured part of oriental medicine[,]

most of which would be preparing oriental medicines,] was estimated at about 120% of the insured expenditure of oriental medicine. ... Even after benefits from the non-insured part were included among their income, oriental medical professionals had financial difficulty. (*OrientalDoctor4*)

It was difficult for me completely to believe his argument. It appeared to be underestimated, since a government official, *GovernmentMember4*, implied that insured oriental medicine was a very small part, telling me that “oriental medicine has almost nothing to do with the NHI”. Nevertheless, it appears that oriental medicine suffers more serious financial pressure than before, primarily because

700 new oriental doctors are produced and enter the oriental medical market every year. ... When I became a [-n oriental medical] doctor in 1979, there were about 2,000 oriental medical clinics in the country. Now, 8,000! My licence number is in the 3,000’s. The licence number of the youngest doctors are in the 15,000’s. How can we survive with 700 new doctors every year? (*OrientalDoctor4*)

In this situation, oriental doctors tend to pursue a lucrative practice, rather than a traditional and essential practice.

Now, oriental doctors have a tendency to be expedient in order to make money. Using some side practice, like treatment for obesity, preparing medicines for increasing height. Or being on a radio or TV program.... If one is famous, one can earn much money. It’s a tragedy (*OrientalDoctor4*).

With such financial difficulty in oriental medicine, pharmacists’ cheap and easily-available oriental medicines are a threat to oriental doctors.

As shown above, behind the conflict there were economic and financial pressures on the individual professions. Particularly, it cannot be denied that the trigger was pulled by pharmacy. Their financial difficulties in health care at that time made them look for an alternative income source in another field. Oriental doctors, who were about to face financial pressure with the rapid increase in their members, could not help sensitively responding to “the pharmacists’ invasion”. Economy and efficiency in preparing herbal medicines were particularly important for pharmacists in arguing for their right. This practical perspective was a threat to oriental doctors, who prepared herbal medicines at a high price.

The first case of conflict between medical professions in Korea also shows that monetary interests of professions largely come from contextual reasons. Over 90% of

medical facilities had been established by individual medical professionals and private organisations, and the government had few plans or policies for professional personnel in health care. Under these circumstances, managing their own medical facilities and making a profit were among the most important purposes for medical professionals.

5.3 Organisational Capacity and Attitude of Oriental Medicine

While interviewing oriental doctors, I could discern the organisational features and capacity of oriental medicine, such as the internal reform and the political process of the Association of Korean Oriental Medicine, which would influence the conflict with pharmacy. Individual professions' professional, social and political attitudes during the conflict also influenced their decision and collective actions. This information has been outstanding and reliable in analysing characteristics of the conflict, particularly because the interviewees were key leaders of oriental medicine.

5.3.1 Leadership of the Association of Korean Oriental Medicine

5.3.1.1 Previous Experience of Conflict with Quasi-Professions

Oriental medicine might be the only main medical profession in Korea that has developed by undergoing conflict with nearby quasi-professions. Contrary to western physicians and pharmacists, oriental doctors have continually suffered from jurisdictional conflict with oriental semi-professionals, such as masseurs or acupuncturists & moxa-cauterisers³⁶. Owing to those situations, “for oriental medicine, no day came without a demonstration (*OrientalDoctor1*)”, causing the Association of Korean Oriental Medicine to reform its executive earlier than any other medical professions.

Before the all-out strife with pharmacists in the mid 1990s, oriental doctors had experienced conflict with blind masseurs³⁷. However, the collision between oriental doctors and blind masseurs over using a needle did not develop into a full-scale strife.

³⁶ Even during fieldwork [in March 2003], the Association of Korean Oriental Medicine was irritated by acupuncturists & moxa-cauterisers. The Korea Acupuncture-Moxibustion Association presented a petition to the National Assembly, arguing that Acupuncturists & moxa-cauterisers should be included in the group of formal medical professionals by amending the Medical Service Act.

³⁷ In 1963, the government had approved the masseur system only for the blind. In 1988, the government allowed the masseurs, who learned the regulated skill of massage, to use specified needles in order to stimulate muscles. At that time, oriental doctors protested against the masseurs' attempt to use needles, “which was not very different from acupuncture (*OrientalDoctor4*)”. Oriental doctors had tried to check blind masseurs' advance in the field of traditional medicine, but failed. The government was on the side of “the social and economic weak, the blind masseurs”. The masseur system monopolised by the blind was one of the government's social welfare plans, not only a health care policy. Under these circumstances, oriental doctors could not press masseurs any more and, at last, had to yield to them.

Oriental doctors did not appear to consider the situation as threatening as the conflict with pharmacists in 1993, since the proportion of income from acupuncture was even less than that from preparing oriental medicines.

At that time, there had been only about 4,000 [now, 8,000] oriental medical clinics, which earned income for preparing oriental medicines at more than double the price. (*OrientalDoctor4*)

Nevertheless, it was considered the first prominent conflict which oriental medicine experienced. During the conflict with masseurs, oriental medicine underwent reform of the Executive in the Association of Korean Oriental Medicine. Younger oriental doctors blamed the existing leaders for passive reactions and incompetence.

Then old executive members were so rich and patrician that they could not react actively to the change of circumstances to defend and develop oriental medicine. (*OrientalDoctor4*)

The conflict with masseurs was the first chance for young oriental doctors to participate in the Association of Korean Oriental Medicine.

5.3.1.2 Reform of the Association of Korean Oriental Medicine during the Conflict with Pharmacy

According to *OrientalDoctor4*, the influence of the young generation in oriental medicine became even stronger with the start of the conflict with pharmacists in 1993. Right after the government deleted the provision in the Enforcement Regulation which prevented pharmacists from prescribing and selling oriental medicines, the then president of the Association of Korean Oriental Medicine, Dr. Ahn was removed from leadership. Dr. Heo, new president of the Association of Korean Oriental Medicine, appointed younger oriental doctors to help him. Up to 1996, Dr. Heo's executives led demonstrations and strikes. Although the Association of Korean Oriental Medicine experienced two more presidential changes during 1996 to 1997, the oriental doctors' fight against pharmacists and the government during that time never faded.

Through the conflict with pharmacists, the average age of the Association of Korean Oriental Medicine executives lowered dramatically. Oriental medicine was the first medical profession to experience a shift in generation within a leading group.

Although the position of the president was still the province of older members, the executives, who decided and led actions in practice, became younger. (*OrientalDoctor4*)

As shown in the key leader's interview, reform of the Association of Korean Oriental Medicine executive preceded strong action by oriental doctors during the conflict. It was also identified in a comment by a member of the lower ranks in oriental medicine at that time.

I believe, as other oriental doctors do, that, at that time, the leadership of the Association of Korean Oriental Medicine was outstanding. We had only one belief – we should not withdraw and should defend ourselves against the pharmacists' invasion. We had never had such a strong feeling and action. However emotionally we responded, it was... great. They [the executives of Association of Korean Oriental Medicine] did well (*OrientalDoctor3*).

5.3.2 Collective Actions

With fewer than 10,000 members, oriental doctors showed strong solidarity in the conflict with over 40,000 pharmacists.

Then... during the fight with pharmacists, oriental doctors unbelievably actively obeyed the executives of the Association of Korean Oriental Medicine. Closing down their clinics, demonstrating on the streets and in front of the government buildings, writing a slogan in blood, having a sit-down strike, along with performing a fast for several days.... All oriental medical students abandoned their classes and attended demonstrations. Thousands of oriental doctors had their heads shaved [to express their determination to fight]. In mobilising either money or persons, there was absolutely no problem. Oriental doctors contributed a lot of money for the fight. Old and rich members individually donated ... thousands and millions of Won [£ 5,000 to 10,000] more or less. Me? About 5,000,000 to 6,000,000 Won [£ 2,500 to 3,000]? I donated as well. Almost all members from all over the country shut their clinics and came to Seoul for a demonstration. It was really extraordinary. (*OrientalDoctor4*)

One interviewee gave his experience when their first general demonstration was held in Seoul.

Last night [of the first general demonstration], my colleagues and I went up to Seoul by taxi [the distance from his resident city, Pusan, to Seoul, is similar to that from London to Newcastle in the UK]. At that time, we believed we should follow the leadership of the Association of Korean Oriental Medicine, without condition. And.. you know, it was related to the demonstration culture in Korea. We thought that we should be radical and violent to attain our purpose. Being rational would bring us loss, we

thought. Under the situation, we never considered, never tried to judge, if the leadership of the Association of Korean Oriental Medicine was right or not. (*OrientalDoctor3*)

Oriental doctors' actions were vigorous and radical. Their solidarity was rarely broken during the long fight for three years, and their collective actions were said to be "more radical than that of trade unions (*OrientalDoctor1*)".

5.3.3 Managerial and Political Capacity

One prominent strong point about oriental doctors during the conflict was their communication network through the internet. This was early in the period when PC communication was being supplied to the public.

We had our own .. powerful bases in Chollian and Hitel [the biggest internet portal sites at that time]. The sites were connected with the Association of Korean Oriental Medicine and actively operated during the fight. We were the first to make and actively use the internet network. By using the internet communication system, we could make emergency calls whenever necessary. Because oriental doctors were young [, we could use our personal computers and the internet]. Now [2003], the average age of oriental doctors is just 31. (*OrientalDoctor3*)

The communication network on the internet brought oriental doctors not only fast collective activity, but also strong actions led by the younger generation.

In general meetings of representatives of oriental medical professors, there was internal conflict between the old and the young generations. They [old members] were ... just modest. So, [in the meetings, younger members were pushed by the older ones in power] I uploaded all the minutes of meetings on to the internet. Then, young doctors criticised the meeting [led by older members]. So, decisions could not help but go right. All data was open to all members through the internet. Only after we did that, pharmacists and western physicians realised the importance of the internet communication network. (*OrientalDoctor1*)

5.3.3.1 How to 'Persuade' the Political System

I barely managed to obtain information about the internal process of "persuading", that is, lobbying. *OrientalDoctor4* showed me how to contact individuals 'when something breaks out'.

We usually take the following steps that people may call a lobbying protocol. There are three groups that oriental medicine has to contact: the Office of the (Korean) President and the Executives, government

officials and the National Assembly. In addition, the Association of Korean Oriental Medicine executives also contact the press and asks for its cooperation. (*OrientalDoctor4*)

It is usually hard to find information about the internal process of lobbying directly from an important internal player. Here, I have rearranged and now present his statement.

As for the Office of the President (of Korea) and the Executives, we would meet the Senior Secretary to the President for Welfare Policy. At this level, we would tell him our difficulty. At the same time, we would suggest a strategy consistent with the government's long-term policy, which would be valuable for the government to attempt in order to tackle the issue and develop public health. The strategy surely is one that oriental medicine will benefit from. We would also meet with the Minister of Health and Welfare, the Minister of Finance and Economy and the Prime Minister. The Minister of Health and Welfare is an absolutely crucial gate to the success of our 'work'. The Minister of Finance and Economy has the key to the national granary. Most issues, particularly increasing fees for oriental medical services in the National Health Insurance, are related to financial support from the Ministry of Finance and Economy. So, we have to obtain guarantees from the Minister of Finance and Economy in advance. The Prime Minister would arrange work between the two ministries, so we would also have to explain situations to him. In most cases, the Senior Secretary to the President for Welfare Policy does not come forward at first. Softening up Ministers comes first, and the Senior Secretary to the President for Welfare Policy gives brief comments later. But, in a particular and serious case, the Senior Secretary to the President for Welfare Policy is actively concerned.

Secondly, in addition to the highest level of the political system, we would also have to meet with government officials in the Ministry of Health and Welfare responsible for the emerging issue. The most important thing is that a meeting with government officials should go BEFORE a meeting with the Minister of Health and Welfare. These government officials are usually the director of a bureau, a section chief and a department chief. At this stage, explanations and alternatives given to the government officials would be very specific. We had to make them understand the importance of the situations and persuade them to accept our requests. After the Minister of Health and Welfare had met us, if he put questions about the issue to his subordinate officials responsible for it, they would give the Minister proper answers. Those answers are what we had given them a few days before the meeting between the Minister and us.

If there was no contact with officials in advance and they could not answer the Minister's questions, our work would face difficulty. The government officials would be unhappy with the situation, about which they had not yet been informed. In that case, even if government officials received an order to devise a plan related to the issue from the Minister, they were reluctant to follow it. By delaying it or doing it as just a passing job, they would not actively cooperate in devising a draft bill.

Therefore, to obtain active cooperation from government officials, we would have to supply enough information and explanations to government officials in advance. In addition to government officials in the Ministry of Health and Welfare, we also had to contact officials in the National Health Insurance. However, the main stem for a policy is still the group of government officials in the Ministry of Health and Welfare.

Thirdly, we have to meet members of the National Assembly, specifically, members of the Health and Welfare Committee in the National Assembly. However, meeting leaders of the Committee for Policy and Planning in the government party and in important opposition parties is more important. Leaders in the committee in every party are actually key players, who decide individual parties' positions and let members of the Health and Welfare Committee in the National Assembly represent each party's position. When a bill suggested by the Executives comes before the National Assembly, persuaded members of the National Assembly would help the bill pass³⁸.

In addition, to create an atmosphere in our favour, we have to furnish news materials to the press. There are different levels of newspapers and broadcasting companies. We have to consider that there is delicate conflict, that is, competition, between them. For example, there are three newspapers at the first level: The Chosun Ilbo, JoongAng Daily and The Dong-A Ilbo. For them, materials have to be delivered all at the same time. (*OrientalDoctor4*)

This statement shows how the process of "persuasion" flowed in the political and administrative world. In addition, it is convincing information, since it came from experiences of a key leader, who has taken charge of the process in oriental medicine since the mid 1990s. That process was firmly established during the conflict with pharmacists.

Generally, the process of lobbying or "persuading the political world" in oriental medicine appears to have been a systematic, experienced and stable one. Compared with pharmacy, there were a few salient differences in the lobbying process. Oriental medicine appears to have established a typical lobbying process as a pressure group. As a player outside the political system, oriental medicine made a habit of targeting key individuals. By contrast, pharmacy appeared to have had a fundamental strong point when contacting the political system. In the Ministry of Health and Welfare, there were many government officials who had been former pharmacists or had obtained pharmaceutical licences. In fact, pharmacists had already influenced the government with their strong network. In that situation, it was not difficult for pharmacy to contact the centre of the political

³⁸ The process of legislation in South Korea starts with a suggestion of a bill. Over 90% of all bills are now suggested by the Executives. After arriving in the National Assembly, A bill is specifically examined by a designated Committee. Then, at a general meeting, the National Assembly decides whether they pass the bill or not. The bill also requires confirmation by the President of Korea, who has veto right.

system. When contacting other political members, pharmacists actively used their personal networks. By employing personal networks, pharmacists showed a strong influence on the government and political system.

During the conflict with pharmacists, oriental doctors had not yet finished establishing their process of persuading the government and the political area. However, pharmacists already had their own refined network and process to those systems. That might be why oriental medicine did not win, in spite of strong public support.

5.3.3.2 How to Handle Government Officials

Oriental medicine had its own strategies to enhance and reinforce its political influence. Key leaders of oriental medicine who were interviewed took the following examples: supporting a candidate for a member of the National Assembly, making an oriental doctor responsible for the Korean President, persuading and lobbying influential members in the political field to support the Bureau of Oriental Medicine. In addition to these “general” strategies, there was personal access to government officials. Key leaders knew that curing an important person in politics or a high-ranking government official of his disease was effective. Below is another example of how oriental medicine faced government officials.

He [a new high government official in the MOHW] started his post only one year ago. Naturally, he may not have known the whole history or specific cases up to now. It might be difficult to even understand and remember medical terms and names of medicines or medical facilities. Anyway, he has a vulnerable position to persuasion or attack by us. It is not very difficult to shake a government official, if a medical profession wishes to do. We, as other professions often do, we would exhaust every means to ‘persuade’ an official. We would threaten or browbeat him, by saying something like - “such a decision will kill [seriously harm] all oriental medical clinics!” Then we would issue a statement. We... might have even his private weak points. You know, ... Of course, I am often tormented by those actions of mine. What on earth I am doing now? But, sometimes there is such a serious battle with other medical professional groups that we cannot afford to distinguish fair means from foul. (*OrientalDoctor4*)

This showed how specifically the executives in a profession considered the personality and characteristics of a government official responsible for their work. Although it is difficult to believe that the strategies and their effects suggested above would always work, *OrientalDoctor4*’s statement implies how “actively” a profession, not only oriental medicine, might play in order to contact and persuade important players in the political and administrative area.

5.3.3.3 How to Gain Public Support

During this conflict with pharmacists, oriental medicine obtained strong support from the public. People believed that oriental medicine was a representative national heritage, and that it had played an important role in keeping the Korean national spirit and culture alive.

We [oriental medicine] had an appealing image. In our society, nationalism still works, you know. We [Koreans] cannot refute the image of ‘traditional medicine’, ‘ancestor’, something like that. In addition, we [oriental medicine] had a smaller number of members than pharmacy had. The image of ‘the weak’ also appealed to people. (*OrientalDoctor3*)

In 1996 during the conflict, the Jogye Order of Korean Buddhism, the biggest Buddhist order in Korea, announced its support for oriental medicine. In its statement, the Jogye Order claimed:

The government should establish measures and systems to protect and develop oriental medicine, the Korean traditional science (Buddhopia, 1996).

As shown in the statement, the code of “national” or “traditional” in oriental medicine appealed strongly to the public during the conflict.

During the conflict with pharmacists, our main weapon was a publicity campaign in the press. We decided to go on with appeals to the public and it seemed to work. People appeared to have compassion for traditional medicine, actually as a traditional thing. Pharmacists were fatally wounded by our attack with publicity activities. On a few occasions, we were also directly hit by pharmacists’ bombs on the press. Pharmacists used to issue statements that oriental medicines were fabulously expensive and that oriental doctors were almost thieves or defrauders. But the public was on our side. We spent tons of money on information campaigns. It was a campaign war, particularly through the first year. (*OrientalDoctor4*)

At the last stage, the judge was the people. Public opinion took their hands for us. It was based only on common sense... like a western costume vs. a Korean costume or a western house vs. a Korean house. People believed that there were western medicines and Korean medicines, and for each, there were [western] pharmacists and oriental doctors. Therefore, they believed that Korean (oriental) medicines should, naturally, belong to oriental doctors. (*OrientalDoctor1*)

An interviewee from the press confirmed that, at that time, people had taken the position of oriental medicine in health care and its professionalism.

People were displeased with pharmacists. Without examining a patient's pulse, only selling oriental medicines like instant teas? People thought that pharmacy neglected public health. So, people seemed to be on the side of oriental medicine. (*Journalist2*)

5.3.4 Oriental Doctors' Attitudes

In the middle of the oriental doctors' actions, they felt the pride that they were the heir of an important national heritage.

While studying oriental medicine, we approach Korean history, to put it strongly, with nationalism. We oriental doctors believe that we are the last and desperate defenders of our tradition. The government guessed that we intentionally mobilised parents of our students in demonstrations, but that's not true. Oriental medical students' parents also deeply sympathised with the attitude of their sons and daughters. Whose parents tried to commit suicide on the bridge of Han River for the sake of their children's study? It was possible only because it was oriental medicine. From entering an oriental medical college, a student and his family had a particular pride and ... a kind of a mission. (*OrientalDoctor1*)

The interviewees from oriental medicine did not hide uncomfortable feelings against pharmacists with regard to the conflict in the mid 1990s.

Oriental medicine is, strictly to say, not science from the perspective of the western paradigm. It's hard to give evidence, visible evidence, I should say. But pharmacy... is very scientific and analytic. I cannot yet understand how pharmacists with such a so-called modern and scientific background tried to take away oriental medicines with a totally different paradigm? Only for an economic purpose! Still I cannot understand. Do they have any belief in their profession? (*OrientalDoctor3*)

With such an attitude, oriental doctors were easily enraged by the pharmacists' attack. Oriental doctors believed that, most of all, it was an attempt to damage their essential pride. In addition, oriental doctors felt superior to pharmacists, although not to western physicians.

We, particularly young oriental doctors, have some kind of feelings... that we might be in a middle position between western physicians and pharmacists. (*OrientalDoctor4*)

This identity, or maybe identity crisis, tended to give oriental doctors a feeling that they could not forgive pharmacists, who had "impudently" tried to trespass on their

profession. The following emotional and rather impulsive descriptions of pharmacists reveal a part of the attitude of oriental medicine toward pharmacy.

Pharmacists seemed to fight rough-and-tumble, because most of them were women and somewhat immature...? Sorry, but.... their style looks like.. doing something with a do-or-die spirit, maybe because... they had sometimes sold cheap medicines and other times dispensed medicines at their own discretion. Pharmacists had to meet many kinds of people, and actually, they had to be businesswomen. That may be why they became so practical and tough. On the contrary, our academic characteristic itself is not specific or sharp, but round and blunt. Professional theories of oriental medicine are metaphysical, abstract and non-material. An oriental doctor's personality attempts to incorporate those kinds of features. Oriental doctors are poor at quarrelling. So, in conflict between pharmacists and us, actually, we could not keep up with pharmacists, who were so practical and tough. (*OrientalDoctor4*)

The statements of the interviewees strongly implied that oriental doctors felt their own superiority to pharmacists. Further, the interviewees did not want to acknowledge that pharmacists were rivals, that is, medical professionals. In the midst of conflict, these kinds of feeling appeared to transform into intolerable ones, such as “dare to face us”.

As shown above, during the conflict with pharmacy, oriental medicine developed their organisational features, capacities and strategies. First of all, their prior experiences of conflict with quasi-professionals such as blind masseurs had helped oriental medicine take more stable and better-organised actions during this conflict. With the previous experiences, they had accumulated know-how and strategy in facing conflict and leading collective actions.

During the conflict with pharmacy, oriental doctors reformed their association by accepting younger generations as their executives. The political capacity of oriental medicine to persuade the public and other outside groups appeared to be superior to that of pharmacy. Furthermore, the solidarity among oriental doctors was stronger than it was among pharmacists. All these strong organisational features brought oriental medicine success in taking collective action and obtaining support from the public.

5.4 Organisational Capacity and Attitude of Pharmacy

5.4.1 Leadership of Pharmacy

All interviewees, except for pharmacists in the low rank³⁹, believed that the Korean Pharmaceutical Association skilfully and cleverly responded to the conflict. Key leaders

³⁹ Because the members of pharmacy had to directly face patients' reproach and anger during the conflict, they criticised the Korean Pharmaceutical Association. Even in this case, their criticism

of the Korean Pharmaceutical Association (KPA) judged that the source of their influence might come from the organising capacity of the “Head Office” of the KPA. Pharmacists called their leading group in the KPA the head office, not the executive. This implied that there was a difference between the leading group in the KPA and those in other medical professions. Pharmacists had a stronger and more skilful leadership.

However, pharmacists had not had such a strong leadership until the conflict with oriental medicine began. During the conflict, young pharmacists “realised problems of the then leading group” and followed a process of seizing power. *Pharmacist3* described the emergence of the younger generation in the Korean Pharmaceutical Association.

Like the present KPA, we had already suffered serious internal strife, ousting the then president of the Association from his post.... During the conflict with oriental medicine, about 300 young pharmacists flocked toward the KPA. We took and occupied the head office of the KPA, confining the then president in a room for over 10 hours and demanding that he quit his position. “You are disqualified as our president! Get away from the presidency!” Arguing and fighting... At last he announced his resignation, but a legal action followed that *coup d'état* and it lasted for a year. The then president won the lawsuit and returned to his presidential post. Then we found a point of mutual agreement. The reformist group would actively participate in leading the KPA with the president by taking over policy-making and emerging as the real power group. In those days, I was a leader of the harsh *coup d'état* (*Pharmacist3*).

After a series of internal struggles in the Korean Pharmaceutical Association, that is, “the *coup d'état*”, the lawsuit, the court struggle and compromise, young reformists with a powerful driving force were allied with the conservatives in the Korean Pharmaceutical Association and their mature experiences and rich networks.

Pharmacist3's experience of internal reform in the KPA head office was harder than that of oriental medicine, as implied in his expression, *coup d'état*. The prominent thing was that it had not been exactly a shift in generations. Pharmacy united the old conservative and the young reformist in its group during its long war with oriental doctors and then western physicians.

In the presidential election of the Korean Pharmaceutical Association in December 2003, which was the first direct election in the KPA, the reformists “formally” came into power by making their candidate, Won, win. It has been 10 years since young reformists first emerged to manage the KPA. Unity between the conservatives and the reformists worked as one of the strongest points in the KPA, particularly compared to

focused on the poor strategy of the Korean Pharmaceutical Association to public opinion, without commenting on systematic or legal results.

other medical professions. Through two occasions of serious conflicts with other main medical professions, pharmacists have survived or almost defeated others. It cannot be denied that the capacity of the strong head office in the KPA came from the unity between two different factions.

During the interviews, I recognised that leaders of the Korean Pharmaceutical Association were prominent elite members within pharmacy. In explaining the well-functioning head office in the KPA, the manpower of the leading group could not be excluded. Here, members of the leading group did not only belong to the head office of KPA, but also to the government and other pharmaceutical fields.

Pharmacy is one of the most popular occupations for women in Korea. To enter pharmaceutical universities requires a good record in high school and a high score in the Entrance Examination. After graduating from pharmaceutical universities and passing the Licence Examination, most female pharmacists open their pharmacies and enjoy stability and high income from their occupation. However, for male pharmacists, opening their own pharmacies does not seem the best course. They often need more active jobs and dynamic activity. That is why all key leaders of the head office in the Korean Pharmaceutical Association are male pharmacists with the best academic and social backgrounds. For the same reason, young and competent pharmacists have continually entered the government and developed their own areas.

Leaders in pharmacy, either in the KPA or in the government, had the best educational background in pharmacy. This feature might have particular meaning in explaining the capacity of the leading group. When the young pharmacists took power in the head office of the KPA, they found their influential colleagues and seniors in the government and other institutions. Those former pharmacists in the government and present pharmacists in the head office of the KPA easily banded together, based on their similar academic backgrounds. They also shared concerns about identity of pharmacy in the medical professional system.

In western medicine and oriental medicine, however, all competent and talented members remained as doctors, practising medicine in their own clinics or hospitals. As a result, there have been few former western physicians or oriental doctors in the government, although any western physician and any oriental doctor can apply to a government official. This situation was reflected in the leadership of western medicine and oriental medicine. Without an individual *coup d'état* within western medicine or oriental medicine, competent and active professionals there have not been interested in their association. Even after the primary *coup d'état* in western medicine, competent

reformists who joined their executives found only that there were no allies in the government or other fields.

5.4.2 Managerial and Political Capacity

When it came to collective actions by individual professions, such as demonstrations or strikes, pharmacists appeared to lose, because the public seriously criticise their strike.

During the first fight [with oriental doctors], ... Even until then, we were immature in responding to such an event. We had no idea how to fight, how to respond. At that time, there were many different opinions and interests within [pharmacy]. Over a strike, our opinions were divided – cons and pros. Anyway, we did strike. But... it was not consistent. Closing pharmacies, opening, closing again, opening again.... Like that. We failed to show our power; we only gave people inconvenience. So, ... we .. were drowned in people's blame. (*Pharmacist1*)

During the conflict, pharmacists were seriously criticised for invading another group's area and attempting to damage Korean traditional culture. Upon such a less refined strategy, a key leader commented as follows.

We learned much from the conflict [with oriental medicine] and our loss [from it]. (*Pharmacist3*)

While losing in the public arena, pharmacists won in the legal and political field by obtaining essential academic bases for their long-term development. The government gave a promise that pharmaceutical colleges would have a 6-year training period. More importantly, the separation system in western medicine was enforced in 1999 by the revised Pharmaceutical Act. Creating a new profession, oriental pharmacy, was another gain for pharmacy. The existence of oriental pharmacy implied that oriental medicine would also be divided in its function, and that pharmacists had used their logic in oriental medicine, where holistic practice is essential. Based on these gains in pharmacy, it is possible to conclude that pharmacists won in the legal and political fields. Upon the conflict situation, one of the most important leaders in pharmacy commented as follows:

The conflict with oriental medicine was, in fact, a fight, of which the result had been clearly revealed from the beginning. We could not defeat oriental doctors, in any way, over preparing oriental medicines. The key was... how little we could lose. (*GovernmentMember3*)

Considering his comment and the pharmacists' legal gains shown above, a possible interpretation is that the pharmacists' main purpose was not only to obtain the

right to prepare oriental medicines. In terms of the conflict with oriental medicine, pharmacists appeared to want a more fundamental system from the government, such as the separation system, which would reinforce the pharmacists' professional position. From this perspective, the conflict with oriental medicine was, for pharmacists, a prelude to the next conflict with western physicians. Then, pharmacists might more clearly understand the influence of the separation system on health care and better prepare for a conflict, which would be provoked from the new scheme.

What made it possible for pharmacy to win when responding to the government and the political system? One of the most persuasive reasons for pharmacists' success was the support and influence of government officials, who were former pharmacists. They lined up in the Ministry of Health and Welfare. In addition, pharmacists also had a fine network with other subsidiary organisations in the government, such as the Korea Food and Drug Administration (KFDA). An opponent of pharmacy, *OrientalDoctor4*, who knew much about the atmosphere of the government, stated,

Influence of pharmacy works very well in the Ministry of Health and Welfare. From a 7th-grade position to the highest in the bureaucracy, there are officials from pharmacy. According to a line, a chain of command, those officials are everywhere. Either in the first conflict between oriental medicine and pharmacy or in the second between western medicine and pharmacy, those officials did everything, from drafting to deciding policy. (*OrientalDoctor4*)

He also talked about how personal and elaborate the KPA's management style of government officials was.

If a government official, even if his position is not high, is in mourning for one of his family members, the Korean Pharmaceutical Association sends out representatives to extend its condolences. Someday, that official might have a high position. Influence of pharmacy accumulated in such a way is tremendous and must be another strong (pharmaceutical) association in the Ministry (*OrientalDoctor4*).

However outstanding their achievement was in facing the government and other social groups during the conflict, pharmacists said their first conflict was "only a lesson".

In the conflict with oriental medicine, we came to understand what would be important in conflict with other social groups. If we failed to suggest a professional vision or... a political meaning in arguing for our rights, we would not get any promise [from the government]. And, we had to form a good relationship with civic pressure groups and with the

political system, in order to win the conflict [with oriental medicine]. It was a very good lesson. (*GovernmentMember3*)

As he expected, the pharmacists' political capacity was more prominently revealed in the next conflict with western physicians.

5.4.3. Pharmacists' Attitudes

When facing oriental medicine, pharmacists did not feel inferior or defeated. Pharmacists believed that they could compete with oriental doctors over a professional position in health care.

There would be nothing particularly difficult about oriental medicine. Pharmacists assumed that by accumulating experiences of preparing oriental medicines, they could do as well as oriental doctors. (*GovernmentMember3*)

Therefore, for pharmacists, preparing oriental medicines was not so difficult. In addition, the pharmacists interviewed did not believe in the efficacy of oriental medicine.

I cannot believe in any practice in oriental medicine. How can one doctor see and treat all, so many different, diseases? Nonsense! (*Pharmacist4*)

Pharmacists belong to modern western medicine, and their professional paradigm does not accept oriental medicine as a major medical profession. Such an attitude on the part of pharmacists later matched western medicine's attitude toward the issue of unifying western medicine and oriental medicine.

As shown above, contrary to oriental medicine, which had had previous experiences of struggle with quasi-professional groups, this was pharmacy's first time facing a conflict with another group. In this conflict, pharmacy reformed their association in a strong way, suffering from inconsistency and confusion in their collective actions and from criticism by the public. This implied that their organisational capacity and strategies were inferior to oriental medicine. Nevertheless, pharmacists obtained considerable gains from their practical and systematic perspectives of obtaining licences to prepare herbal medicines and securing the government's promise that the separation system would be enforced. Their achievement appeared to result mainly from the support of their colleagues within the government, who strongly influenced the legal and systematic results of the conflict.

5.5 Government and Other Environmental Factors

5.5.1 Role of the Government

Government officials from pharmacy actually made the conflict open. The oriental doctors interviewed commented that the starting point was “neither a vision of health care nor a long-term plan (*OrientalDoctor4*)” in the government.

I can tell you that no work, no policy in the Korean government follows a large prepared picture. Bureaucrats do not systematically work. I think it's a very common structural problem in the government.
(*OrientalDoctor4*)

The government's starting point and its later responses were said to reflect such unplanned government work. Oriental medicine was also displeased with “complete lack of concern about oriental medicine by the government” until the open conflict began.

At that time, there was no one in the government or in the political system, who had any concern about oriental medicine. Without understanding oriental medicine and its identity, it was hard [for the government] to form a budget and make a policy for oriental medicine.
(*OrientalDoctor3*)

After the conflict, the government decided upon and enforced political measures for the development of oriental medicine by establishing a separate bureau and an institution, preparing a law, designing a long-term plan “to identify the importance of oriental medicine”. With pharmacy winning systematic and academic gains from the government, it appeared that only the government might “lose”, by yielding to diverse schemes for both professions. That was a problem, because these schemes were not well prepared but designed only to appease collective actions of the two professions. Furthermore they would become individual causes of coming internal and external conflicts among the professions concerned.

Meanwhile, based on *OrientalDoctor4*'s statement about how to persuade the political system, the top political class, such as the Korean President's Office, appeared to be deeply involved in decision-making of important medical policy. It also became clear that during this process government officials were considered to be as important as high-positioned politicians. Giving government officials related information in advance, in order to give a proper answer to the Minister, made the process smooth and fast. Nevertheless, the process showed that political access still occurred prior to administrative access. Without agreement or arrangement in a political field, it appeared hard to achieve something only with administrative attempts.

During the interview with *OrientalDoctor4*, I asked if the Association of Korean Oriental Medicine had requested government institutions or related institutions to study a specific topic in advance to use the outcomes as a rationale for your argument.

There had been few such cases. Most important cases had been sudden and urgent, and there had been no such room for studying elegantly [in a leisurely way: a sarcastic expressions for academia] in advance. (*OrientalDoctor4*)

At this point, we also can infer that a practical and political approach would occur prior to a rational one in attempting to at least arrange important or imminent matters.

5.5.2 Role of Civil Pressure Groups

During the conflict between oriental medicine and pharmacy, civil pressure groups played an important role as an arbitrator. As the government lost the trust of the professions, particularly of oriental medicine, their alternatives to settle the conflictual situations were criticised and then declined. Here civic groups rapidly emerged as an effective and trusted arbitrator between the two professions⁴⁰. The fact that they were important supporters of the then president and his government was another reason why they played such an influential role. Although the role of civic groups was weakened as the conflict developed, their alternative in the early stage helped the government settle the conflict.

In addition to the role of an arbitrator, civic groups produced plenty of important comments on situations and specific events during the conflict as opinion leaders. Oriental medicine and pharmacy attempted to attract civic groups to their side to obtain public opinion.

At that time, the matter was which profession could co-opt more civil pressure groups. It was another battle between pharmacy and oriental medicine. We.. and they as well, did anything. (*OrientalDoctor4*)

Although different opinions came from civic pressure groups, major ones supported oriental medicine “to protect a traditional heritage”. In fact, civic pressure groups were in line with public opinion, which gave strong support to oriental medicine. A representative of civic groups (*CivicGroupLeader4*) and a member of the press (*Journalist2*) confirmed it.

⁴⁰ Park, S. (2000) argues that Social Capital of the Citizens’ Coalition for Economic Justice, such as trust and cooperation, made it possible to settle the conflict between oriental medicine and pharmacy.

5.6 Interpretation of the Conflict

The first case of professional conflict in Korean health care had important implications not only from the practical perspective but also from the academic one. It showed different and contestable points in Abbott's theory in 1988, as well as those consistent with his arguments.

5.6.1 Implications of the Conflict

The conflict between oriental medicine and pharmacy in the mid 1990s was a typical jurisdictional conflict, as suggested by Abbott (1988). The two professions collided with each other over the issue of prescribing and preparing herbal medicines. Over this specific jurisdiction, they faced each other with different professional knowledge, perspectives and prides. Behind the conflict, there had also been economic and financial motivations. Monetary interests mattered more for pharmacists. They had been under financial difficulties from the rapid increase in their membership and the number of medical clinics.

Nevertheless, it is difficult to argue that the economic motive was the only factor in the conflict between oriental medicine and pharmacy. The controversial jurisdiction, preparing 100 specified oriental medicines, was not one to create a huge amount of income, sufficient to give a large influence on both professions. Rather, the conflict was more about professional identity and professional position. Pharmacists were desperate to strengthen their professional identity in health care. From this perspective, the pharmacists' conflict with oriental doctors was a way to re-erect their professional position by arguing for the separation system and a 6-year training system guaranteed by the government.

5.6.2 Environmental Factors of the Conflict

5.6.2.1 Experience of Conflict and Organisational Development

As Abbott (1988: 82-83) argues, the social organisation of the professions affected professional claims in the Korean case presented above. He suggests that the more strongly organised a profession is, the more effective its claims to jurisdiction. He also suggests that professional organisation, particularly the existence of a single, identifiable national association, is a prerequisite for a public or legal claim. However, his arguments about the professional organisation explain only a part of the conflict between oriental medicine and pharmacy. There were more important aspects in the Korean case.

First of all, in the Korean case, each professional organisation was not only an

independent factor, which would affect its claim and conflict, but also a dependent factor, which would be affected by the conflict. When they faced those conflicts, each profession experienced internal reform that included a change of leadership, a shift in generations and an emergence of reformists within the leading group. As shown in pharmacy, an organisational reform could take a strong form like a *coup d'état*.

Both professions had already established their own national association with local branches, specific academic societies and diverse departments. Therefore, both had a well-organised association at least officially. The conflict between both professions gave each of them a chance to change their association into a more developed and more qualified one. With the conflict, the professions also developed their managerial capacity. One of the most prominent managerial points during the conflict was establishing and employing internet communication networks in oriental medicine. Their younger average age and more active leadership made that possible. The internet communication network contributed not only to oriental doctors' fast and strong collective actions but also to democratisation within oriental medicine by providing all of the information to every member.

In addition, the conflict developed political capacity between the professions concerned. Both professions learned more about how to contact and persuade other groups, such as the government, the political field and civic pressure groups. They attempted to find and mobilise all possible networks and lines. They also learned how to persuade other groups and the public. They would work by trial-and-error but that became a valuable lesson for the next conflict. The pharmacists' strike was a good example. Their strike against oriental doctors and the government was revealed almost as a failure, and they had to face huge criticism from the public. This experience made them more cautious when employing a strike in their next conflict with western physicians.

5.6.2.2 Other Internal Factors

Abbott (1988) argues that internal differentiation and the existence of dominant power in a professional system are important social factors which influence jurisdictional conflict among medical professions. It is difficult to identify an internal hierarchical differentiation in the relationship between oriental medicine and pharmacy. From the perspective of professional position and a training system, oriental medicine is superior to pharmacy. Oriental doctors are doctors who take a 6-year university training course, while pharmacists are close to technicians with a 4-year university course. In contrast, pharmacy has strong scientific knowledge from the perspective of western medicine. Pharmacists also have a better-organised network in the government. Therefore, it is

difficult to tell which profession has dominant power.

5.6.2.3 Social and Cultural Factors

Going back to Abbott (1988: 144-145), technology and scientisation were presented as important issues and factors to the conflict. They provided a base for pharmacy when claiming their qualification to prepare oriental medicines. Oriental medicine faced the pharmacists' logic with their own paradigm that oriental medicine is not required to be visible, evidential or analytic. Although the public acknowledged that pharmacy had scientific and advanced technological tools, they did not believe that pharmacists could prepare oriental medicines only with their advanced technology. The public support for oriental medicine was evidence that belief in modern technology did not diminish people's consciousness of national and traditional values.

As another cultural factor, professional education in universities had more meaning in the Korean case than Abbott suggests in his western-based theory. Professional education in universities was not only a factor which influenced professional claims, but it was also a result, a gain, of conflict. After the conflict with oriental medicine, pharmacy obtained permission from the government for a 6-year training system, as exists in western medicine and in oriental medicine. Koreans have a great deal of enthusiasm for higher education⁴¹. For the Korean people, higher education not only has practical or professional meaning, but it also has a meaning of prestige for a higher social class. From this perspective, a longer education in pharmaceutical universities will heighten not only their professional position in health care but also the social position of pharmacy. Pharmacy looked forward to lengthening their training period, knowing that that would prevent their being ignored any further by oriental doctors and western physicians.

The professionals' attitude was another key in the conflict. Oriental doctors considered the pharmacists' attack an insult to their pride in a national heritage. In addition, as shown in the sector on individual professional attitudes, professionals had particular feelings towards their opponents. That might have come from hierarchical or class-consciousness originating in the Confucian culture and military hierarchism or it could simply be contempt for a different profession. In this case, those feelings and attitudes caused strong reactions and collective actions from both professions.

⁴¹ While developing the country since the 1960s, the government has emphasised that the country would have human resources. A recent OECD survey showed that Korea is the first to record 95% of the young population (25-34 age) attaining at least upper secondary education (OECD, 2001).

5.6.3 Who Regulated the Conflict?

Abbott suggests that professional claims would break out in the following three arenas: public opinion, the legal system and the workplace. By comparing competitive situations in the legal arena, the workplace and public opinion, he attempts to explain who would regulate the conflict and control the situations. Then, the government's position and role would be suggested.

5.6.3.1 Claiming Sole Jurisdiction in Different Arenas

The conflict in Korea also had the three battlefields. However, the Korean case was too complicated and too dynamic to be explained only by Abbott's comments. In the workplace, there were few cases in which oriental doctors and pharmacists collided with each other. In fact, there were few chances for both sets of professionals to meet each other in practice. They did not relate to each other as doctor and pharmacist, because their fields - oriental medicine and western medicine - were different. There was neither an order-and-obedience relationship nor cooperation with each other in the workplace.

During the conflict, oriental medicine and pharmacy actively used the press to influence public support. Not only by publishing articles, broadcasting news items on the air or sending out ads, they also attempted to win public support by attracting important figures in the press and in civic pressure groups. However, these attempts addressed only a part of the public opinion arena.

The most important and prominent methods for professions to claim jurisdiction for themselves were street demonstrations and strikes. The key was "being radical". Collective actions were "physical" in the true meaning of the word, with radical and extreme demonstrations being typical and original forms of collective action in Korea. Facing a military dictatorship until the end of the 1980s, labour, political and social movements had to take a hard and extreme line. Collective actions taken during the conflict between oriental medicine and pharmacy followed such a typical form of movement and included highly educated professionals. At that time, other social groups, such as trade unions, were changing to a more rational and prepared style of movements. As the groups coming late to the idea of collective actions, oriental doctors and pharmacists were more naïve and clumsy than other groups in their approach to applying pressure during the conflict.

Abbott suggests the importance of co-opted external authority in interprofessional competition (Abbott, 1988: 167-168). The fact that individual professions in the above case attempted to make more alliances including civic groups or others would be an example. In fact, those external groups were alliances for the professions during the

conflict. However, they were not so strong or organised that particular oligarchic professions would be identified, as would be in Abbott's explanation.

Abbott emphasises the arena of public opinion as a pathway to the legal arena, where a system or a policy can officially form. However, in the Korean case above, these two fields were not exactly linked to each other. Although oriental doctors obtained almost overwhelming support in public opinion, pharmacists appeared to win in the legal system, because pharmacy had a support group of trained pharmacists *in* the government. Under the situation, the legal system tended to be more favourable to pharmacy than to oriental medicine.

While acting in the legal arena, the two professions had different strategies. Although oriental medicine had a refined and well-organised lobbying process to persuade the political and administrative system, it was typical of the form that an interest group would take. In contrast, pharmacy had their colleagues, ex-pharmacists and government officials, within the government, who were well informed about the whole process in the political and administrative system. Therefore, the starting point in the legal arena for each profession was different. For oriental medicine, the leaders of the Association of Korean Oriental Medicine needed to persuade the government to play for oriental medicine. However, leaders of the Korean Pharmaceutical Association did not need to do that, since government officials, former pharmacists, were already working in favour of pharmacy. Regardless of how well oriental medicine had used the lobbying process, oriental doctors might not catch up with pharmacy in the legal arena.

5.6.3.2 Role of the Government

In the conflict between oriental medicine and pharmacy, the pressure of public opinion was an important factor in policy making. However, setting specific regulations and erecting new systems in the legal arena, specifically in the administrative field, was more important in settling the conflict. Those two situations were not exactly consistent. The fact that pharmacy won the important systems in the legal arena, in spite of their loss in the public arena, shows the point. Therefore, the first case of conflict in Korean health care implied that the political capacity of a profession to reach the government was still more important in settling the conflict. It shows that the first conflict and its settlement in Korean health care were, in fact, near to the French style, in which the executives are more influential than the legislature or public opinion in professional policies (Abbott, 1988: 157-164), although pressure from public opinion was high in the legal arena.

The government was actively involved in the conflict between oriental medicine and pharmacy and suggested new schemes to settle it. Although, in the early stage of the

conflict, the government lost control over the situations and a civic group's alternative was chosen as a settlement, final settlements were reached individually between the government and pharmacy and between the government and oriental medicine. The settlement in the original controversial issue was small, resulting in pharmacists who pass the temporary qualification test being allowed to prepare the specified oriental medicines. However, the new legal and systematic schemes that also emerged as a result of the conflict were more important and fundamental than the original result. Those large and expanded results, such as creating oriental pharmacy, enforcing the separation system and permitting the 6-year training course in pharmacy, caused an even bigger conflict in health care.

Nevertheless, the government did not and could not lead or control the situations, because dominance on the political level and on the bureaucratic level was different. Oriental doctors had a strongpoint in the political field and with public opinion, while pharmacists had gains on the bureaucratic level in preparing specific regulations.

5.6.4 Conclusion

The conflict between oriental medicine and pharmacy over preparing oriental medicines had more meanings from the perspective of professional conflict than are outlined in Abbott's cases from western countries. The Korean case had not only a jurisdictional conflict, but also more complicated components, such as monetary interests and professional motivation. Although monetary motivation was an important factor, professional pride appeared to be more important, because the conflict related more to professional identity and position with a long-term and large vision than to practical and economic benefits.

All of these points were interrelated and emerged in every stage. The complexity of the conflict with its diverse backgrounds made the situation more dynamic, since any action from one profession provoked a stronger reaction from another. Therefore, professionals' claims in the public and legal arenas took more diverse and dynamic forms.

Prominently different from Abbott's theory (1988), professional associations evolved alongside their conflict with another profession. This might be an outstanding result from the first open professional conflict in health care. The managerial skill and political capacity of their leading group developed through the conflict.

Regarding social and cultural factors, rational ones, such as technology or professional knowledge, appeared to be less important than emotional and ideological points, such as nationalism, political influence or social class-consciousness, particularly for the public. Public opinion was an important factor and pressure in making a policy.

Civic pressure groups played an important role in arousing public opinion.

However, setting specific regulations and erecting new systems in the legal arena, specifically in the administrative field, was even more important in the conflict. Although an arbitration scheme suggested by a civic pressure group was officially chosen in the legal process, detailed administrative processes and regulations were devised by the Ministry of Health and Welfare, where the government officials who were former pharmacists had considerable influence.

With the conflict, both medical professions found an opportunity to develop their fundamental professionalism, not only their specific organisational capacity. Oriental medicine was guaranteed by the government a long-term development plan to heighten their professional position. Pharmacy was also promised by the government the separation system and a new training system in pharmaceutical colleges. This implies that, in spite of hard experiences, both professions in conflict were able to strengthen their professional and social position in terms of the very conflict.

CHAPTER 6. CONFLICT BETWEEN WESTERN MEDICINE AND PHARMACY OVER THE SEPARATION SYSTEM

In Chapter 6, I discuss and analyse the second open conflict in Korean health care, which occurred between western medicine and pharmacy during 1999~2003 over enforcement of the separation system. It took place three years after the previous conflict between oriental medicine and pharmacy had ended. This chapter shows how this second open conflict was related to the first one. In addition, it analyses how the second case was different from the first one in its causes, features and situations, and how the groups concerned responded to different and changed situations.

The Development of the Conflict section, which is based on the comments of key players in the conflict, shows dynamic inside situations, more than a simple chronological process, existing during the conflict. The following section presents how the jurisdictional conflict developed in a more complicated way than in the first case, how economic motivation was closely related to the conflict and how the conflict developed into a political one.

This chapter includes discussion and analysis of organisational development within the individual professions involved in the conflict. The result of this analysis shows how and why western medicine and pharmacy employed different managerial and political strategies. This chapter also analyses how the government and civic pressure groups responded in experiencing the second open medical conflict.

By analysing the biggest open professional conflict in Korea, this chapter reveals characteristics of the professions and of the professional system in Korean health care.

6.1 Start and Development of the Conflict

6.1.1 Development of the Conflict

The separation system in western medicine is made for a strict division of medical roles between western physicians and pharmacists. Under the system, western physicians can only prescribe medicines and pharmacists can only dispense medicines according to western physicians' prescriptions. In 1963, the principle of separation between prescribing and dispensing of medicines had been stipulated in the Pharmaceutical Act, but remained unenforced until 2000.

According to the Pharmaceutical Act, which was revised in 1994 as a result of conflict between oriental medicine and pharmacy, the separation scheme would be enforced by the government in July 1999. In 1998, the new liberal government hastened

to organise the Conference for Separation Scheme and make out a draft of the scheme. However, by amending the deadline in the Medical Service Act, the government again delayed enforcement of the system until 1999.

1999: Start of Setting the Separation System and Western Physicians' Uprising

To meet the new deadline, July 2000, the government had to rush. In March 1999, the Civil Committee for the Separation Scheme, which was composed of five influential civil pressure groups⁴² participated as an arbitrator between the two professions during preparations of the scheme⁴³. On 10th May 1999, the presidents of both professional associations signed a mutually-agreed scheme, the so-called 5.10 Agreement. However, it soon turned out that it was not to be the end, but only the start of a fierce conflict.

In November 1999, six months after the 5.10 Agreement, the government carried out the Repayment System Based on the Real Price of Medicines. Until then, medical facilities had obtained *margins* from the difference between the official inflated price of medicines, which had been applied to trade between medical facilities and the NHI Corporation, and the real low price of medicines, which had been applied to trade between pharmaceutical companies and medical facilities. With the new repayment system, the government repaid western physicians for used medicines at the real low transaction price of medicines.

Every western physician was shocked with the enforcement of the new Repayment System. Although the government increased the medical services fee by 9%, the new repayment system led to a slump in the income for all medical facilities. Paradoxically, this implied that western physicians had relied on their margin in managing their clinics much more than the government had investigated or expected. Only by losing medicines and margins from their hands did western physicians realise the real meaning of the separation system. However, passage of the separation system bill was imminent in the Plenary Session of the National Assembly. (*Journalist I*)

⁴² Five civil pressure groups, which joined the Civil Committee for the Separation Scheme, were the Citizens' Coalition for Economic Justice, the Green Consumers Network in Korea, the People's Solidarity for Participatory Democracy, the Consumers Union of Korea and the YMCA of Korea.

⁴³ At that time, civil pressure groups were the strongest supporters of the new government and of the new President of Korea, Kim DaeJung. Most members of the groups came from the circle of people who had challenged the military dictatorship in Korea during 1970s and 1980s. The President's career also showed his history of suffering in the face of military dictatorship. Therefore, the new President and the civil pressure groups held a political ideology and social values in common.

On 30 November 1999, around 37,000 western physicians gathered to censure the government and to check the separation system in the JangChung Gymnasium. This first demonstration was larger than even western physicians themselves had expected. It was the beginning of the struggle by western medicine.

2000: Western Physicians' Strike with Strong Defiance to the Separation System

The year 2000 started with the western physicians' strike and a change of leaders in the Korean Medical Association. The current president of the Association, Dr. Yu, was impeached for signing the 5.10 Agreement. Physicians denied the Agreement, because they argued that it was a few leaders' arbitrary decision, not that of most western physicians. As younger western physicians became the new executives, the Korean Medical Association heightened the level of its struggle. On 20 June 2000, western physicians started their third strike all over the country. On the 5th day of the strike, a summit meeting between the President of Korea and the leader of the leading opposition party was held to discuss the medical disturbance. On 25 June, the Korean Medical Association called off the strike, because they believed the government would entirely re-examine or revise the separation scheme. On 1 July, the Separation System was set out as specified in the Medical Service Act, leaving room for revision. By the end of July, however, interns and residents [trainee doctors] in hospitals started a further strike and insisted on a strong fight by the KMA. In August and October, a series of additional western physicians strikes broke out.

In October 2000, the government suggested the Conference of Med-Pharm-Gov for meetings among western physicians, pharmacists and the government to revise and fix the separation system. After subsequent meetings, the government drew up the Agreement of Med-Pharm-Gov., which western physicians just managed to accept. However, pharmacists were reluctant to accept it, because an injection was not included in the scope of the separation system.

2001: Government's Announcement of Financial Difficulties in the NHI and Western Physicians' Fighting against the Government

In March 2001, while pharmacists were protesting at the government's decision, the National Health Insurance Corporation announced a serious financial crisis. The conflict entered upon a new phase. Earlier in the conflict, the government had increased fees for medical services in the National Health Insurance five times. However, at this point, the

government turned its whole medical policy toward improving the financial situation of the NHI.

In May 2000, the government announced a Comprehensive Plan to Overcome the Financial Difficulty of the NHI, which included cutting fees for medical services. Both professions opposed that plan with western physicians strongly objecting to both the plan and the government. In June, medical hard-liners who opposed the government and the separation system took power in the Korean Medical Association. These new executives declared a firm fight against the government. From this time, the conflict changed from primarily being among western physicians, pharmacists and sometimes the government to one between western physicians and the government. While western medicine was in serious conflict with the government, pharmacy moved into its stage of stability, accepting the separation system and the government's decision.

From the end of 2001, the biggest issue in Korea gradually emerged: the direct Presidential Election of Korea in December 2002. Most western physicians appeared to want this Presidential Election to bring a change of the existing government.

We realised that we needed a comprehensive and political way to let the separation system be completely re-examined. Doctors regarded the Presidential Election of Korea as the critical point in their struggle. We eagerly hoped the existing government would change.
(*WesternPhysician03*)

2002 to Early 2003: Western Physicians' Politicisation and the Presidential Election of Korea

In 2002, while western physicians demonstrated three times, the separation scheme appeared to stabilise and fix its position. People were accustomed to the new system and pharmacists adapted to it. There still appeared to be hope for western physicians. Until the end of November, there was no doubt that the Presidential candidate in the conservative party, whom western physicians supported, would win. However, a dramatic reversal occurred at the last moment of the Presidential Election. Roh, the Presidential candidate who was from the progressive party in power and was also a stronger and younger reformist than the then President, won the election.

In March 2003, western physicians chose their former president, Dr. Kim JaeJung, as the new president of the Korean Medical Association, ousting the existing president Dr. Shin, a young and hard-line activist.

6.1.2 Who Drove the Separation Scheme?

After the 1998 inauguration, the new President of Korea, Kim DaeJung⁴⁴, and his new executives recognised there were fundamental and complicated problems in Korean health care. The government also knew that the separation scheme would face difficulties with regard to those organisational problems.

Nevertheless, they decided to carry out the scheme, expecting it would be a trigger to reform of the whole medical system. The new government's keynote in those days was 'eradicating irregularities and corruption in all systems'. Taking advantage of the keynote and the social mood in those days, the reformists exposed 'evil and illicit margins' in western medicine. (*Journalist1*)

In the Ministry of Health and Welfare, there were a few government officials from pharmacy, who prepared the new scheme. They realised the professional identity crisis in pharmacy.

In the past, 70% of medicines were sold in pharmacies. However, since the National Health Insurance scheme for the entire population came into force in 1989, over 50% of medicines began to be sold in clinics and hospitals, with pharmacists mainly selling over-the-counter medicines. We lost the authority to prepare important medicines. With the compulsory NHI, we began to doubt our function in health care. (*GovernmentMember3*)

To survive as a medical profession, pharmacists believed that there was no alternative but for them to accept the separation scheme. The leaders of pharmacy acted in concert with the government and persuaded pharmacists in the ranks to accept the separation scheme.

Although the DJ government [the existing Korean President Kim DaeJung and his liberal government] ignited the separation system, ... there was no driver, who would hold the steering wheel. Soon, the leaders of the Korean Pharmaceutical Association began to emerge as .. the DRIVER of the new system. And .. I was willing to be the JangJaBang [the first advisor] for pharmacy, .. the government and the political system. I informed the government and the political system of difficulties in pharmacy and persuaded them to consider our difficulties in their decision-making process. ... I believed the separation system should be a scheme to include pharmacists. (*GovernmentMember3*)

According to an important interviewee, a few former pharmacists in the Ministry of Health and Welfare were mainly responsible for devising the separation scheme.

⁴⁴ It was the first win of a presidential candidate from a liberal and reformist party in Korean history.

Pharmacists' leaders then played an active role in enforcing the separation system, since they saw it as their "last option for survival as professionals in health care". With increasing numbers of western physicians and oriental doctors, pharmacists could not function as "small doctors" any more. In order to keep their position as a profession in the Korean medical system, pharmacists had to return to their original role, "the one and only profession about medicines (*Pharmacist3*)".

A few western physicians agreed with the new government's intention and ideology and supported the separation system by furnishing an academic base for the separation system. They were key members of the Association of Physicians for Humanism (APH)⁴⁵ and most had graduated from the Seoul National University. Unlike most western physicians, they had continually emphasised the importance of the public health care system and its expansion.

Among the small number of "progressive (according to pharmacists)" or "communistic (according to western physicians)" western physicians, Dr. Kim YongIk, a professor in the medical college at Seoul National University, was a key leader. In 1999, he published a very controversial newspaper article entitled "I Didn't Train My Students to be Thieves". The article exposed the "black margins" in western medicine. It was the starting point for the reform of the medical system to eradicate *margins*. According to western physicians, the article was the signal for 'killing [seriously damaging] western physicians' by denouncing them as an immoral group and pushing them to give up their privilege and wealth.

Under these circumstances, the only group strongly opposed to the separation scheme was western medicine. The Korean Medical Association and western physicians were enraged, because the government was attempting to eradicate their main income source, the *margins*. In addition, the government "had already known, ignored and even encouraged the margin (*Journalist1*)". Western physicians became angry, because a very few western physicians from the Association of Physicians for Humanism had betrayed their colleagues, all western physicians. Denounced as medical thieves who only pursued illicit benefits, medical professionals suffered a blow to their pride

6.2 Different Motivations and Perspectives of the Conflict

6.2.1 Conflict over Professional Jurisdiction

According to my interviewees, specific controversial issues in the conflict were related to

⁴⁵ The Association of Physicians for Humanism is a voluntary organization of doctors. The APH was the minority in medicine, to which less than 1.5% of all doctors belonged (APH, 2001). Until 1999, by putting into action the spirit of humanism, such as free consultation for the old in rural areas, it had maintained a good image in the public and with other western physicians.

two kinds of professional jurisdiction. One covered the right to prepare medicines, the other, the right of practice.

6.2.1.1 First Jurisdictional Issue: Right to Prepare Medicines

The right to prepare medicines was the most essential issue through out the conflict. Western physicians argued that the right to prepare medicines should belong to them, because preparing medicines was a part of their medical practice with patients.

First of all, western physicians argued that pharmacists might know well about medicines as specific commodities, but they did not know more than western physicians about the effects of medicines in the human body (*WesternPhysician13*). Because western physicians underwent clinical training for at least six years, they believed that their ability to prescribe medicines meant that they were approved as professionals of medicines as well (*WesternPhysician05*).

Therefore, many western physicians argued that they should prepare, as well as prescribe, medicines in order to supply the best medical services for patients. In addition, western physicians were sceptical of the pharmacists' professional role.

Are they professionals? What do they do? We already give instructions in taking medicines when we issue our prescription.
(*WesternPhysician05*)

According to another interviewee, western physicians were afraid that they would lose their professional influence, if they lost the right to supply medicines for patients.

In Korea, patients might get well when they realise that their medicines directly come from doctors. Why do you think there are so many injection prescriptions in Korea? Patients will feel that they have a special, an advanced treatment, when they are being injected. Even highly educated people feel this way. Under this cultural situation, without medicines, western physicians would considerably lose their professional authority and ability from patients[, because a doctor's consultation without medicines would psychologically affect a patient's trust in the effect of the treatment]. They are anxious about this, regardless of the reduction in income. So, western physicians instinctively didn't want the separation system. Actually, in rural areas, if a patient is given a new red pill instead of an existing blue pill, he shows a strong resistance, although both pills are the same medicines. "It's strange. I don't like it!" The patient believes that he won't get well with the 'strange' pill. Experiencing such cases, western physicians have learned that there certainly are remedial effects by just an action of giving medicines. As a result, western physicians psychologically reject the separation system. (*Journalist1*)

Against these western physicians' arguments, pharmacists insisted that the right to prepare medicines was their original jurisdiction and should remain their monopoly. Basically, "when it comes to medicines", all pharmacists interviewed argued that they were 'absolutely superior to doctors'. Pharmacists had a pride that they were the only professionals of medicines. Based on this belief, pharmacists criticised western physicians.

Western physicians do not know much about medicines, even though they are prescribing them (*Pharmacist1*).

6.2.1.2 Second Jurisdictional Issue: Right to Practise on Patients

The right to practise, known as the doctors' monopoly, was another jurisdictional issue, although not as external as the right to prepare medicines. Western physicians were worried that pharmacists would attempt to invade doctors' monopolistic jurisdiction.

Pharmacists should do only their original work, which is preparing medicines as western physicians prescribe them. But Korean pharmacists have for 50 years been used to prescribing medicines like doctors. And they still want to do that. They want the right to prepare medicines by themselves without doctors' prescriptions. (*WesternPhysician09*)

In enforcing a complete separation system like the present scheme, doctors' monopolistic right of practice should be guaranteed. But under the present situation, the doctors' position is very weak. We [Koreans] have many other doctors - oriental doctors and, additionally, pharmacists, who are half-doctors with only common sense knowledge of health care. In this situation, there is no position for western physicians. Pharmacists should give up the intention that they practise on patients. It's the doctors' exclusive right. (*WesternPhysician08*)

According to western physicians, the pharmacists' purpose in arguing for the 6-year training system and for using substitution medicines was to see patients, as a doctor does. Western physicians' opposition to the pharmacists' new training system was strong. Western physicians believed that pharmacists "would invade the doctors' monopoly after their rudimentary clinical practice (*WesternPhysician10*)".

In fact, pharmacists expected that their new 6-year education would compensate for their lack of clinical experience.

For over 20 years, pharmacists have considered and demanded the 6-year training system. ... Now all the circumstances have matured. With the separation system, pharmacists can become true professionals of medicines. ... It's timing. (*GovernmentMember3*)

Western physicians also approached the issue of preparing substitution medicines, another hot issue in the conflict, from the perspective of a professional right. Substitution medicines are medicines with similar efficacy to those western physicians originally prescribed. Western physicians opposed expanding the scope of substitution medicines, while pharmacists insisted on it. Western physicians worried that preparing substitution medicines could invade their professional decisions. According to western physicians, by permitting substitution medicines, pharmacists, who had functioned as general practitioners until then, would still function in the role of “small doctors”.

As shown above, the conflict over the separation system implies a more complicated situation than in Abbott’s conception of jurisdictional conflict. The two professions had to give up one jurisdiction to obtain another monopolistic jurisdiction: western physicians had to give up their right to prepare and sell medicines for their sole right to prescribe medicines, while pharmacists had to abandon the right to prescribe medicines for their monopolistic right to prepare and sell medicines.

The conflict was focused on the former jurisdiction, the right to prepare medicines. However, behind the western physicians’ resistance, there was another important but less visible jurisdictional issue, the right of practice. This implies that the conflict was not a linear one, in which there is one defender and one attacker over one portion, but a complex and multi-dimensional one, in which individual players are both attackers and defenders at the same time over two areas. That is one reason why the conflict over the separation system was more complicated than Abbott’s, although it was still a jurisdictional conflict as he describes.

There was another factor which made the jurisdictional conflict severe. Western medicine and pharmacy were the most important professions in Korean health care. In addition, the controversial jurisdictions were the most essential fields for each individual profession. Therefore, the conflict extended beyond the specific jurisdictions to the issue of professional identity and pride.

6.2.2 Conflict over Economic Benefit

To understand the conflict over the separation system, the economic factor could not be ignored, although most professionals denied it. The analysis of the origin and development of the *margin* and economic motivation for the individual professions will help us to understand the characteristics of the conflict.

6.2.2.1 How and Why *Margins* of Medicines were Created

One of the hottest issues in the separation system was the *margin* of medicines. The *margin* of medicines⁴⁶ meant hidden payment to western physicians and pharmacists from pharmaceutical companies. It came from the difference between the official overestimated price of medicines under the National Health Insurance and real lower trade price of medicines agreed upon between western physicians or pharmacists and pharmaceutical companies. In principle, the *margin* was hidden and involved illicit payments. However, in practice, it was “customary and inevitable, and even the government knew about and condoned it”. On this point, all interviewees once agreed.

The following comments on the historical background came from interviews with a high government official (*GovernmentMember4*), a representative of a civic pressure group (*CivicGroupLeader4*), a politician (*GovernmentMember2*) and two journalists (*Journalist1* and *Journalist2*). Their individual statements about the origin of the *margin* were almost the same. Considering their positions, which were not necessarily on the side of western physicians, and their knowledge of the inside circumstances of government, ‘the inevitability of the margin’ appeared to be persuasive.

In 1976, considering only the Japanese social health insurance system, its fee system and the Korean economic level at that time, the government introduced a social health insurance scheme in haste, without enough preparation. It should have included a reasonable system of fees for medical services in advance, but there had been no study, and there was no fund for payment to western physicians. Because of this, the government chose a scheme that provided a low level of contribution with a low level of benefits at a low level of payments. It was a crude form, but devisers expected that it would be continually revised. Outside the social health insurance scheme, there were customary fees for medical services. The fees for medical services in the social health insurance scheme then became 45 to 50% of the existing private customary fees.

At the starting point of the health insurance system, health insurance was available only for a limited group, workers in large industries with 500 or more personnel and their families. There were no serious problems with that system either for western physicians or for the government.

In the 1980s, the situation totally changed. Coverage by the health insurance system rapidly expanded, and since 1989, the government has enforced a compulsory health insurance program for the entire

⁴⁶ There were different kinds of margins. “Landing Cost” arose when doctors in hospitals selected new medicines for the first time. Pharmaceutical companies rewarded doctors or hospitals for accepting their items. After “landing” new items, doctors or hospitals often obtained remuneration, the so-called “Rebate”. In most small clinics and pharmacies, an “Extra” came and went. Doctors obtained extra medicines from pharmaceutical companies, not money. In an extreme case, an Extra was 900%, meant that real trade price of a medicine was 1/10 of official trade price (Won, 2003: 23).

population. However, levels of fees in the health insurance system have hardly changed. Afraid of public resistance, the government and politicians did not increase the level of contribution and payments for western physicians. Therefore, the price of medical services in the NHI had to stay at a very low level. Meanwhile, since the mid 1980s, the number of western physicians has rapidly increased, and the pharmaceutical industry in Korea has developed rapidly.

Pharmaceutical companies have produced plenty of copied medicines at low cost, some of whose patents had expired. Because the official market price of medicine was still high, pharmaceutical companies obtained huge benefits. During that time, competition among pharmaceutical companies became more severe. Pharmaceutical companies supplied their medicines at a lower price and gave back other diverse benefits to western physicians, in recognition of their using the items⁴⁷. Therefore, there were two kinds of prices for medicines: the real transaction price, available between western physicians and pharmaceutical companies; and the official inflated price, available between western physicians and the National Health Insurance Corporation. The gap between the real transaction price and the official swollen price of medicines flowed into medical facilities and pharmacies as margins.

The margin from the pharmaceutical industry began to 'display its ability' by compensating western physicians for low payments from the National Health Insurance and allowing the government to avoid the risk of increasing the contributions of the insured (*GovernmentMember4*; *CivicGroupLeader4*; *GovernmentMember2*; *Journalist1*; *Journalist2*).

'A distinctive feature of Korean medical culture' played another important role in increasing the price of medicines in the NHI, instead of increasing fees for medical services in the NHI. In Korea, there has been a tendency to value visible and specific goods, not things of invisible or abstract merit, such as professional consultation or advice. The same case is applicable to medicines. Patients are willing to pay for medicines or injections. However, even a decade ago, or even now in rural areas, the western physicians' invisible practice, such as consultation, medical decisions or brief treatments were often considered "free services" added to medicines or injections. In this culture, it was easy for the government to increase the price of medicines, instead of medical services in the NHI. Here is an example from *WesternPhysician10* experience, which shows the medical culture in Korea.

[It was] when I took an internship in a hospital. Three- or four-year-old babies came to the ER, having their elbows dislocated. It was deadly painful. At first, we X-rayed, though we knew it without an X-ray, because we had learned about it in anatomy. "Hold on tight to your baby!" Then aiming, turning and adjusting only for 3 seconds. Done! The price of the case was 39,000 Won [£ 19.50] in the NHI. The price of recognising, diagnosing and treating was 38,000 Won [£ 19], X-ray

⁴⁷ In 1999, there were over 400 pharmaceutical companies in Korea. 20% of them were small with less than 10 employees (Won, 2003)

1,000 Won [50 pence]. You know? In one among 4-5 cases, parents gave us just a word of thanks and try to just go. Without paying. That's our culture. That's why western physicians need to X-ray. Western physicians need to show the parents what they have done - visibly. "An X-ray costs 39,000 Won [£ 19.50], and I just treated your baby for free." Then they paid western physicians. If I honestly told parents that my treatment cost 38,000 Won [£ 19] and the X-ray was 1,000 Won [50 pence], they would avoid paying. So, western physicians have to be showmen. 3 seconds would have been OK, but they needed 30 seconds, moving and touching the baby's arm, talking to the baby, and explaining, ... anything to show 'something'. (*WesternPhysician10*)

Until 1999, this kind of distorted medical system with extremely low payment for medical services in the NHI had persisted. In order to compensate for that, *margins* of medicines had also persisted for about 20 years. The western physicians' criticism of the low fees for medical services was universal among my informants.

Under the circumstances, *margins* had been an important income source for western physicians. Until 1999, the government had not regulated "the illicit margin", and there had been no conflict over the issue. For all interviewed western physicians, the issue of the *margin* was the most troubling, unpleasant and sensitive. They knew that they were criticised as "thieves" by people because of it. Therefore, they took a longer time to explain its background than they did for any other issues, about which people did not know much.

6.2.2.2 True Amount of the *Margin*?

What, then, was the true amount of the *margin* from medicines? No one knows the exact amount, but for medical facilities, the amount must certainly be over 30% of the official price of medicines. In November 1999, as the first step of the separation system, the government enforced the new repayment system based on the real trade price of medicines.

Before enforcing the new repayment system, the Ministry of Health and Welfare investigated what proportion of the official price of medicines went to medical clinics and hospitals as *margins*. 200 medical clinics and hospitals were selected for the survey. The result showed that 30.7% of the price of medicines flowed to western physicians as *margins*. The government considered this result as the only basis for decreasing prices for medicines and increasing the prices for medical services. However,

... [T]he medical facilities, which joined the survey, did not know the purpose of that research. Doctors only believed that the intention of the survey was to impose a kind of tax on their additional and hidden

benefits called margins. Therefore, they reported smaller, or far smaller, figures for margins (*Journalist1*).

According to the new repayment system, the government cut 30%, or £ 450 million, off the official price of medicines, and they compensated western physicians for their decreased income by as much as £ 450 million through increasing fees for medical services in the National Health Insurance. However, western physicians “got into a panic” with the event and started their demonstrations.

A key leader of western medics, *WesternPhysician03*, was willing to answer this sensitive question.

Now, I think, ... the true margin could be, at that time [before the new repayment system], about 50%. The government compensated western physicians for the loss, which was 30% of the price of medicines, with increase of fee for medical services. But, you know, non-estimated 20% flew away swiftly before our eyes! Imagine that! We had done nothing! Then, suddenly, our benefits slumped! You know, cutting 20% of total benefits means dropping 40 to 50% of net benefits. Western physicians were perplexed, in chaos. Nevertheless, the government said that the government had done their work by deleting illicit margins and increasing fees. Only then did western physicians start to distrust the government. (*WesternPhysician03*)

Journalist1, who was well acquainted with the situation in western medicine, told me about the margin.

So, 30% turned out to be wrong, but no one would know the exact amount. Western physicians did not share this information with even their closest friends. It had been totally up to a western physician’s individual decision. Well, for a western physician with an average conscience, perhaps it could be 30%? For older western physicians 50%? If they were really bad guys, maybe 60 to 70%? For honest western physicians, possibly 10 to 20%? Like that.... Anyway, 30% turned out to be completely wrong. (*Journalist1*)

For pharmacies, margins were handed over to pharmacists in the name of “Pro”, which implied a proportion of discount. The proportion could be 10%, 20% or more of the transaction price of medicines.

It was about... 10% of monthly income. It was considerable, actually. (*Pharmacist5*)

After the separation system, the *margin* for pharmacies, if any, was primarily limited to over-the-counter medicines.

6.2.2.3 Professionals' Economic Motivation

A. Western Physicians' Economic Motivation

Either owing to handling by the press (according to western physicians) or owing to the truth (according to others), the argument that “western physicians followed only money” was easily met during the fieldwork. Only a few attempted to understand western physicians' economic attitudes by considering the structure of health care.

Health care in our country consists of 90% of private medical facilities. They must have similar features to those of private companies, which are naturally sensitive to something which decreases their benefits. (*CivicGroupLeader2*)

Emotional and extreme criticisms against western physicians' economic motivation were to come, as follows.

Examiners of the Health Insurance Review Agency said that western physicians were ... creators, who can make and develop new medical ways to earn money. Wherever examiners cut, western physicians can create new parts to supplement cut parts. (*Pharmacist3*)

In addition, pharmacists did not believe western physicians' “professional motive”. According to western physicians, the reason they opposed preparing substitution medicines was that they attempted to keep their monopolistic practice right. However, the pharmacists interviewed argued that western physicians still wanted margins by prescribing specific medicines from specific pharmaceutical companies.

Western physicians' prescriptions would greatly depend on under-the-table rebates from pharmaceutical companies. Doctors tend to choose a medicine not because it would work well for patients, but because it brings them more under-the-table money (*Pharmacist3*).

Against others' sceptical perspective of western medicine, western physicians had their own logic to defend. While being interviewed, most of them emphasised the structure of health care that would make western physicians “inevitably” pursue financial benefits. They argued that pursuing profits was inevitable in order to run a clinic and to survive in a free market system. Then, western physicians blamed the government for its negligence of the medical system.

If a western physician failed to run his clinic, he would fall into debt for 3 to 400,000,000 Won [£ 150,000 to 200,000]. At a young age, if one was wrapped with such a debt, his whole life would be done. You know, why does a doctor eagerly look for a rich woman for his bride? There is a huge risk in opening his clinic. A doctor from a rich family could reopen, even if his clinic fell down. But for doctors from middle- or low-classes...? (*WesternPhysician03*)

People and the government criticise western physicians for considering only money, but the present health care system also takes a financial approach. Either the government or .. western physicians do not care about quality of medical service. The government only wants to cut the expenditures of health care. Then, western physicians also see patients as money. Western physicians in clinics greet each other in a meeting with, "How many patients do you see in your practice each day?" Basically, it relates to low medical fees in the NHI. For my case, I have patients until 8.00pm, with a maximum of 70 hours a week. Restudying by joining a seminar? Recharging for my life? I never dream of such a life. I just want to take a rest. There's no other way to see as many patients as possible with the present fees. People blame us for 3-minutes practice. I'd like to give a long service with a full explanation to my patients, if I could get 200,000 USD a year only with 20 patients a day, like in the US. I'd like to. Please let me do that. For my clinic, we (he and another western physician) have to see 120 patients a day to make both ends meet. It's tremendous pressure. (*WesternPhysician08*)

Why don't we have fair fees for our practice? Is it wrong? (*WesternPhysician10*)

B. Pharmacists' Economic Motivation

All western physicians interviewed blamed pharmacists for their "unreasonably high fees". They believed that pharmacists did not attempt to earn money in many ways, as western physicians were doing, because "the government protected pharmacists' income [fees for pharmacists in the NHI] enough".

What a large amount the government paid pharmacists in the NHI! How much the fees for them increased with the separation system! The original purpose of the separation system was said to be to check the abuse of medicines. Should the government pay pharmacists so much money just for looking over western physicians' prescriptions and asking western physicians a question on the phone if there's anything wrong? Nonsense! (*WesternPhysician10*)

Pharmacists appeared to be treated less unfairly than western physicians only with regard to fees in the NHI. It was rare for pharmacists to criticise the level of their fees in the NHI during their interviews. That contrasted with western physicians, whose main criticism was the low level of fees in the NHI. However, there were other cases that

showed the pharmacists' economic motivation. The following comment from a manager in a general hospital reveals the first example of pharmacists who move for higher pay.

With the separation system, the pharmacies near a general hospital desperately need pharmacists who are well informed about what medicines are used in the hospital. As a result, they hire pharmacists from the hospitals by offering higher pay. Now we struggle to hire and keep competent pharmacists in our hospital. After experiencing 1-2 years in our hospital, they fly away to nearby pharmacies. Since the separation system, 7 huge pharmacies have been opened near to our hospital,... All the pharmacists there had worked in our hospital at one time (*HospitalManager1*).

Competition for a good pharmacy location was another example. After the separation system, the location of a pharmacy became the most important factor in earning money. According to one interviewee, *Pharmacist3*, the cost of a pharmacy skyrocketed at a premium. In attempting to occupy a prime location near a general hospital or a complex of medical clinics, the old relationships between seniors and juniors, who had graduated from a pharmaceutical university, were broken. For those who were interviewed and managed their own pharmacies, it was one of the most regrettable features.

With the beginning of the separation system, substitution medicines emerged as an economic issue for pharmacists. *Pharmacist3* argued that preparing substitution medicines should be permitted, because pharmacists, particularly those running small pharmacies in villages, could not buy and keep all kinds of medicines in their pharmacies.

I'm telling you, there are not enough medicines in a pharmacy to satisfy all prescriptions. ... I had run a pharmacy, but failed. When I cleared my pharmacy, there were 2,080 kinds of medicines in it. 2,080! ... At that time, I was working as a leader in the Korean Pharmaceutical Association ... While working in that position, some illusion came to my mind that I had to show other pharmacists a successful case of the separation system with my pharmacy. Then, I bought many different kinds of medicines, as many as I could. So? I ended up with 2,080 kinds of medicines. Even with thousands of kinds of medicines, a pharmacist could not satisfy all prescriptions in the world! (*Pharmacist3*)

In the meantime, "poor pharmacies", particularly those located in rural areas, attempted expedient schemes to meet their income. A leader in pharmacy also pointed out that after the separation system there occurred a huge gap in incomes between pharmacies. A large pharmacy near a big hospital or on a hospital street gathered huge amounts of

money. However, a small pharmacy in a small village suffered serious financial difficulties. For the latter, “some skills” would be required. The *Journalist1* commented.

Because of financial difficulties, they [poor pharmacists] adopted expedients. Pretending to be oriental doctors, they prescribed and prepared herbal medicines, and they illegally prescribed medicines for their familiar neighbours. The government and the National Health Insurance Corporation can chase prescription drugs traded without doctors’ prescriptions. Only with a strong intention, can the government catch those medicines and sources by retro-tracing the pharmaceutical industry. But even with that information, the government cannot reveal it. Why? The separation system would break. Would western physicians remain quiet? “That’s it! The very chance!” Western physicians would rise up ... to overthrow the separation system. (*Journalist1*)

As western physicians developed non-insured treatments and some western physicians abused medicines and treatments to compensate for their decreased income, some pharmacists also resorted to those expedients to increase their income.

6.2.2.4 Professional Issue or Economic Issue?

In the conflict over the separation system, on which phase did professions focus: professional jurisdiction or economic benefits? Some interviewees said that the conflict was, in the end, over income or economic benefits (*GovernmentMember2*, *WesternPhysician08*). Other interviewees said that it was about professional pride and rights (*WesternPhysician13*). The complex situations concerned made it difficult to decide. However, an analysis of the following three specific cases highlights important implications for the characteristics of the conflict.

A. Doctors’ Choice: Reinforcing Professional Right or Increasing Fees?

In October 2000, the Conference of Medicine, Pharmacy and Government drafted an agreement with 13 provisions. In the agreement, however, “an essential item for western medicine”, a provision to check pharmacists’ prescribing medicines, was excluded. There was neither regulation nor specification against pharmacists’ prescriptions. Young western physicians suggested that a specific regulation against pharmacists’ prescription should be included in the Agreement. However, the Agreement narrowly passed in

western medicine by a vote of all western physicians⁴⁸. The vote returned, 49:51, showed tight contention among western physicians.

The reason for passing the Agreement was that the existing executives were already satisfied with the increased fees for medical services, and they wanted to finish the long fight. (*WesternPhysician03*)

Young western physicians believed that the most important thing was to create a desirable system which would protect the rights of doctors from the pharmacists' invasion without temporarily increasing fees for medical services. In 2001, the government decreased fee for western physicians because of serious financial difficulty in the NHI.

Considering the series of situations shown above, the argument that western physicians lost a good chance to create a system that would secure their monopoly on prescriptions appears to be persuasive. However, at that time, clinics and hospitals were suffering from financial difficulties under the new separation system. That meant the executive of the Korean Medical Association would not be able to ignore the practical and urgent issue of fees for medical services. At the same time, the Korean Medical Association had a system in which the executive should listen and collect all doctors' arguments by a vote on every important specific issue. In that system, it would be difficult for the executive to actively consider a longer-term situation.

This case indicates how important a practical and economic issue was for western physicians in the conflict over the separation system. Western physicians and the existing Korean Medical Association executive chose a practical and imminent offer, which would directly and instantly influence western physicians, but not ensure a professional right, a long-term and basic gain.

B. Debate on Substitution Medicines

Over the use of substitution medicines, western medicine and pharmacy collided with each other throughout the conflict. Different reasons from individual professions showed how complicated the professional purposes and economic motivations were in conflict. Western physicians argued that substitution medicines would invade their absolute right of practising medicine with patients.

Pharmacists are always ready to go back to being small doctors [primary care doctors] as they did before. Then, permitting substitution medicines

⁴⁸ If an agreement between the KMA and the government and/or pharmacy came out, the agreement should get major support, that is, confirmation, from the rank and file in western medicine by a vote.

would give them the right to be a primary care doctor!
(*WesternPhysician13*)

Once my wife had the flu and I gave her my prescription. When she back from pharmacy, I found different medicines from those I had prescribed. She [a pharmacist] did it without any notice or explanation to my wife nor any comment to me. (*WesternPhysician05*)

The pharmacists' argument was different. They thought the reason why western physicians opposed preparing substitution medicines was the doctors' economic motivation 'after *margins*'.

For a specific kind of medicine, they [western physicians] still receive margins from a [pharmaceutical] company. If he [a western physician in a near medical clinic] changed the medicines he had used, I thought, "Ah, a different [pharmaceutical] company took over the clinic."
(*Pharmacist5*)

All pharmacists interviewed said that the reason they needed substitution medicines was to remove stock.

If we open a box of a medicine item, it usually takes.. about three months for all of it to be sold out. If western physicians stop prescribing 'the' medicine before three months,... then the medicines just accumulate. Plus, we do not prepare only one kind of medicine. How can we manage all of them? (*Pharmacist1*)

Western physicians refuted these arguments of pharmacists.

Changing medicines is our right - our right of practice, right for patients. We know which medicines are better and which medicines are not good for which patients who need different kinds of medicine. Most of all, we cannot change medicines too often. We cannot use awkward medicines, for which there are usually margins. You know why? Patients are not fools. They know a lot about medicines. They come to doctors, already knowing much about the original, or good, medicines. "Doctor, please give me Novask from Pfizer, Zantac from Glaxo, Aspirin from Byer, etc." Even in a city, patients object to taking medicines from an unfamiliar and doubtful company. Rumours fly swiftly. Why would I use an odd medicine to get a farthing? Patients will turn their backs
(*WesternPhysician13*).

In every step of the conflict and every negotiation between western medicine and pharmacy, the issue of substitution was one of the most controversial points. However, the government does not seem to be on the western physicians' side with regard to this

issue. The government decided their policy was to expand the scope of substitution medicines.

Which was more important to professionals – economic benefit or professional jurisdiction or right? Behind the conflict, which motivation would be more active? It was difficult to answer in the case of substitution medicines. Both points became entangled with each other, and individual professions attacked the opposite with their useful perspectives. However, the government chose a practical and economic settlement, one which would decrease the stock in pharmacies and decrease the NHI expenditures that had been paying for expensive original medicines⁴⁹. The conflict appeared to proceed from a financial, rather than a professional, perspective.

C. Debate on Another Copy of a Prescription

During the conflict over the separation system, the issue of how many prescription copies should be issued emerged⁵⁰. The controversial point was whether one copy should be issued for a patient or not. Pharmacists and civic groups argued that a copy of a prescription for a patient would be necessary for a patient's right to know.

However, western physicians, in particular who managed own small clinic, denied issuing one for a patient. Western physicians argued that a prescription would be an important intellectual outcome of western physicians that they did not want to let a prescription be handled rudely by some or most careless patients. According to western physicians, "it would be an invasion of doctors' consultation right (*WesternPhysician13*)". They also asserted that it could provoke distrust between western physicians and patients. However, western physicians' hidden but main concern was that patients would use a prescription once again to get their medicines without seeing a western physician again.

Pharmacists, in particular in a small community, would be willing to accept patients' illicit demands, giving medicines without doctors' new prescription (*WesternPhysician05*).

After disputes between western medicine and pharmacy and a few changes in the government's decisions, the government passed a regulation, which required western

⁴⁹ As one reason for a serious financial difficulty within the NHI, the government claimed that the amount of expensive original medicines in western physicians' prescriptions rapidly increased after the separation system.

⁵⁰ In the 5.10 Agreement reached in 1999, which had been led by the civil pressure groups at the very first stage, 4 copies of a prescription had been specified. Those were for the Health Insurance Review Agency, a medical facility, a pharmacy and a patient. After the 5.10 Agreement broke down, the former two were soon replaced by computerisation. A prescription for a pharmacy was accepted, because it was necessary in preparing medicines. However, one for a patient remained controversial.

physicians to issue another prescription for a patient. From June 2003, a western physician's licence would be suspended, if he or she was found violating the regulation. The issue centred on how western physicians were concerned that their professional right would be infringed upon and how their income would decrease because of that damaged right.

The three cases above, the western physicians' acceptance of the Agreement of Medicine, Pharmacy and the Government without guarantee of their monopolistic jurisdiction of consultation, the controversy about substitution medicines and the controversy about giving a copy of a prescription to a patient showed that the conflict over the separation system encompassed complex disputes over professional rights and economic benefits. It would be difficult for professionals to give up any of them, but the professions and the government decided to take a practical decision from the financial perspective. Therefore, the conflict itself had to go on with such a practical and financial feature.

The economic issue in the conflict over the separation system resulted most of all from the context of Korean health care, in which most medical facilities had been established by individuals and private organisations and the market of medical services had been operating under the free competitive principle. This was the same context for the economic motivation existing in the first conflict between oriental medicine and pharmacy. In the conflictual case of the separation system, what was even more influential was that fees for medical services in the National Health Insurance were even lower than cost. As a result, *margins*, the illicit income, were needed to compensate western physicians for low pay from the NHI.

As Latham (2001) or Rodwin (1993) argue, the fee-for-service system is favourable to western physicians with monetary interests. In addition, in the free competitive market, medical clinics and hospitals competitively introduce new medical equipment and extend their facilities. Because the amount of capital and the investment in facilities are important standards in evaluating medical institutes, medical professionals have to be sensitive to economic benefits. Therefore, doctors and pharmacists in Korea had complicated attitudes as clever managers of their own facilities, businessmen sensitive to financial issues and highly educated professionals with a strong pride.

Beyond the contextual reasons, medical professionals, particularly western physicians, had individual motivations for monetary benefits. As the first and 'only' professionals in health care, western physicians expected 'fair pay' for their professional work and position. When they believed that their expectations had been shattered and

they experienced being attacked as only money-grubbers, they reacted strongly. As shown in the section on the western physicians' attitudes, they responded emotionally to this "unfair" treatment. Western physicians argued that, in spite of their superior professional position, they were poorly treated, while pharmacists, "who were not professionals in health care", obtained unfairly large gains.

6.2.3 Political Ideological Conflict

The conflict over the separation system brought a new issue to medical professions and to interest groups. This issue was whether a profession had an inclination towards a certain political ideology. A key leader of the Association of Korean Oriental Medicine denied it. Although there had been political action by western medicine during the last Presidential Election of Korea, he said, it was only a temporary, weak and particular case.

At that time, the existing government pushed western physicians too much [in order to enforce the separation system]. Nevertheless, even though the Korean Medical Association supported Chang [the candidate of the conservative party], they might have contributed something to both [the conservative opposition party and the liberal government party]. We are, after all, interest groups. There is no other choice.
(*OrientalDoctor4*)

However, there was a certain political movement and inclination among medical professionals concerned. It was outstanding, because there had never been such a political movement among professions in Korea. It was also remarkable, because the political inclination grew stronger as the conflict over the separation system developed. The following analysis reveals what political inclinations individual professions had and how they emerged and were expressed.

6.2.3.1 Political Inclination of the Two Medical Professions

There were a few important points that revealed the western physicians' political inclinations: their attitudes toward the Association of Physicians for Humanism, the liberal government party and the recent KMA's reaction to the Court's judgement on the Health Care Union for Progress and Solidarity.

The western physicians who were among those interviewed had an aversion to the Association of Physicians for Humanism, which supported the separation system and furnished an academic base for the separation system to the government. They pointed out that Professor Kim YoungIk's controversial article, "I Didn't Train My Students to be Thieves", and the APH's 'act of treachery' actually favoured the separation system. There

was more. A few interviewees used the word, *PalGaengYi*, for the APH. It literally means a red-coloured person and is often used to pinpoint a communist with hostility. This implied that western physicians had an antipathy to the APH, partly because of their political ideology.

They [the APH] have no appeal to western physicians. Last time, one of their internal documents, which was revealed to the press, said, “Western physicians belong to the class of capitalist. We have to attack capitalists from the perspective of labourers.” Their expressions, wordings and thoughts were very.. one-way and non-practical... What’s that? They are also western physicians. Then... they will be... *fraktsiya*⁵¹ [secret agents]? Very weird. (*WesternPhysician08*)

In fact, most western physicians interviewed believed that the APH was a “dangerous” group.

The members [of APH] have a different purpose, beyond enforcement of the separation system. They want to socialise the medical system and follow the British medical system. In our country, 90% of the medical facilities belong to the private sector. To decrease the proportion to at least 40%, 50% or 60% would be a delusion, but they think it would be possible. The MDP [Millennium Democratic Party, the liberal government party] re-won the Presidential Election, but one month earlier there had been only a few who had believed that the MDP would win. Because members of the APH thought that DJ’s [President Kim DaeJung’s] period [1998~2002] would be the best and only chance for a contest of single round, they hurried to tear apart and mend the whole medical system in five years. We thought that it would take at least 30 years to make a rational system. We wanted to go with the people. But the APH said, “How could we wait for such a long time? Only a few pioneers can lead and achieve all.” (*Journalist1*)

The commentator above was often criticised by western physicians for his reformist attitude, yet even he thought that APH was “radical”. Therefore, the APH was considered to be almost a communist group by common western physicians.

The new leader of the Korean Medical Association commented as follows during his interview.

Korean health care is a private system based on a free market, democratic principle. 90% of the medical facilities have been established by the private sector. For the last 20 years, the government hardly contributed to it. Nevertheless, the government now grossly interferes in health care. I believe that a private health care system with minimal

⁵¹ From Russian. To Korean people who graduated from a university, this is one of the most familiar words with regard to a political movement.

interference from the government is desirable... in order to develop health care. We should keep it and go with it. (*WesternPhysician09*)

A western physician interviewed was not pleased to hear that I was studying in the UK. He did not like the British health care, because its proportion for public health care is high and he believed that it could be similar to a communistic health care policy. I learned a possible explanation for his comment during another interview.

Pharmacists have argued that they and western physicians should be equal. All others, such as nurses, physiotherapist, pharmacists, etc, etc, all demand equal pay and equal treatment. ... We western physicians become angry when we hear just the syllable *equa-* or *com-* something like that. (*WesternPhysician05*)

In June 2003, the Korean Medical Association made a statement about the Court's judgement on the Health Care Union for Progress and Solidarity, another progressive group in health care. The Court had arrested four key members and judged that the *Health Care Union* was an association "benefiting the enemy [communism or North Korea]", based on the National Security Law⁵². The Health Care Union for Progress and Solidarity had supported the separation system and other public health care policies. Two of those 4 members of the Health Care Union also belonged to the Association of Physicians for Humanism. On the statement, the Korean Medical Association 'positively welcomed the Court's judgement.'

We, the Korean Medical Association, clearly declare that we support the principle of free democracy and that we do not admit any association, which opposes the principle. It has been revealed that members of the Health Care Union led and forced the unification of health insurance schemes and the separation system, in order to achieve a socialist health care policy. The figures behind them are responsible for the deficit within the NHI and the failed separation system. ... We, the Korean Medical Association, declare again that the health care system should follow the principle of free democracy and the free market system and that we definitely oppose all policies and principles against it. (KMA, 2003a)

With regard to the Health Care Union, the statement issued by the Association of Medical Clinics more clearly showed the position of western physicians.

⁵² The National Security Law was established during the military government to protect the country from communists and from North Korea. While the conservatives argue that it is necessary for the nation, the liberals insist that it infringes upon fundamental human rights. Although the liberal party has taken over the government since 1997, the law remains and is only being revised. Amnesty International recommended that the law should be abolished.

Now we know that most western physicians have been suppressed and our fair income exploited, because health care socialism, or health care communism, has been being activated. ... Those who believe in communism forced the absurd separation system to make western physicians into a proletariat. ... We should totally reform the present separation system that the communists devised. (AMC, 2003)

The comments and statements of western medicine indicated that there were two extremely different poles in western physicians' political thought. One pole was about capitalism, the free market system, the principle of competition, privilege and stability. The other was about communism, socialism, liberalism, progressive, reformist and North Korea. Within this dichotomy, western physicians stood at the former end and believed that the separation system was enforced by those at the latter end.

The political inclinations of western physicians developed more fully as the separation system started and went on. Although western physicians had been traditionally known as politically conservative, most had remained indifferent to politics. For example, western physicians who were interviewed from the low ranks had a common opinion about the Association of Physicians for Humanism.

I heard about them for the first time when I graduated from the university. I believed that APH might be great, because they did something... like practising medicine with the poor or with residents in rural areas for free, which common doctors could not easily do (*WesternPhysician06*).

However, their opinion suddenly changed with the separation system, and their political tendency became hatred for the APH and all the other supporters of the separation system. Therefore, it could be said that the separation system was a trigger to make most western physicians politically conservative. In addition, the separation system and its supporters emphasised cooperative relationships or teamwork among health care members. This hurt western physicians' professional pride, because they believed that they *were being exploited* and could easily imagine a communistic society. That is another reason why western physicians became conservative or extremely conservative, as shown in the interviewees' comments and the statements.

Pharmacists also had a certain political tendency, although not as strong as that of western physicians. Compared with western medicine, they were politically liberal and progressive. Their reaction to the Health Care Union for Progress and Solidarity also supported this comparatively liberal tendency. Pharmacists blamed western physicians for 'old and anachronistic conservatism, which was shown in the statements' made by the

Korean Medical Association and other medical associations, through the messages on the bulletin board of Korean Pharmaceutical Association.

All the western physicians interviewed believed that the existing Korean Presidential candidate for the liberal government party, Roh Mu-Hyun, would have a socialist ideology. For them, the candidate was “radical” enough to be avoided as a future President. However, a pharmacist who was interviewed had attempted to support the candidate of the Democratic Labour Party at first (*Pharmacist1*), who from the doctors’ perspective was even more radical than Roh. Western physicians could hardly consider the candidate of the Democratic Labour Party as the President of Korea, because for them, Roh was already too radical.

6.2.3.2 Another Battlefield: the Presidential Election of Korea in 2002

As the conflict over the separation system became more intense, medical professions and political powers became polarised into western medicine and the conservative opposition party versus pharmacy, the liberal government party and civic groups. The Presidential Election of Korea in 2002 expressed that polarisation.

In the 2002 Presidential Election, the point was whether the liberal party in power, the Millennium Democratic Party (MDP), would win again. Would the conservative opposition party, the Grand National Party (GNP), win back power five years after they had lost it for the first time? Until November, Lee Hoi-Chang, the candidate of the GNP was leading the campaign. The majority of western physicians supported Lee. Western physicians believed that the existing government caused all disorders in health care. In addition, western physicians, most of whom belonged to a high society, did not like “the radical and inexperienced liberal party”. Western physicians looked forward to a change of regime and “wished that the new government would stop the whole chaos (*WesternPhysician08*)”.

Under the situation, the executives of the Korean Medical Association openly supported Lee Hoi-Chang, the candidate in the opposition party. Then, with a dramatic reversion at the end of the election campaign, Lee in the GNP lost the Presidential Election. Most western physicians among interviewees judged that the Korean Medical Association had been “very unskilled” in coping with the Presidential Election. Pharmacists also pointed out the KMA’s risky action, that is, supporting a specific party, during the Presidential Election. Even *Journalist1*, who is one of the most objective commentators in health care, criticised the KMA’s one-sided campaign.

It was not good. The KMA was very unskilled. Some recommended the executives should not support Chang [Lee Hoi-Chang] in public. “You should not do such a thing in politics. Even the GNP [Lee’s party] would not like it, either, because people do not like a party which western physicians support. If you really want to support him, just give money to the party.” In spite of that advice, a few guys pushed their plan. In fact, the executives wanted to express more strongly the doctors’ support of Chang, but Chang’s camp disapproved of that. (*Journalist1*)

In spite of the criticism above, the activist in the Korean Medical Association, who led the election campaign for the President of Korea, had his own reason for supporting the opposition party. First, the Korean Medical Association executive decided “there had been no *organised* political influence in the KMA”. During conflict with pharmacists and the government, they had desperately looked forward to an organised influence on the political field, the government, civic groups and the press.

[In those circumstances,] we [the KMA executive] had decided to take a specific and clear way in the political field as a first step into politics (*WesternPhysician03*).

Secondly, according to *WesternPhysician03*, during the election campaign, the camp of Roh Mu-Hyun from the liberal party in power “completely excluded western physicians”. The liberal party in power professed to be a representative of the weak, the middle and the low classes.

[In such circumstances,] there was no other option but for us [the KMA] to ally with the conservative party (*WesternPhysician03*).

Thirdly, the medical policy of the government party was certainly not favourable to western physicians. Candidate Roh of the government party made it clear that the separation system and other reforms in the medical system would go on. In addition, he declared that he would enforce the Ingredient Prescription and expand the scope of substitution medicines. Those public promises on the medical field were exactly opposite to what western physicians wanted. Instead, Candidate Lee Hoi-Chang of the opposition party declared that the separation system would be re-examined.

[Then,] we [the KMA executive] realised that there was nothing to lose any more, even if we supported only the conservative party (*WesternPhysician03*).

The KMA's attitude during the Presidential Election in 2002 was the first case in Korea where an influential profession expressed a particular political disposition. There was a certain issue of medical policy, the separation system, which was addressed by the KMA's political action. Therefore, it would also mark the first time an interest group, the Korean Medical Association, attempted to use a political approach to manage its problem or conflict in public. However, the attempt did not have internal agreement or support. Only a few executive members and an action group actively led the KMA's strategy for the Presidential Election campaign.

The aftermath of the action by the small leading group was bigger than expected, when "our [western physicians']" candidate, Lee Hoi-Chang, unexpectedly lost. Three months later, the existing Korean Medical Association executive failed to win in the president election of the Korean Medical Association. Nevertheless, as the players of the Korean Medical Association wished, the political influence of the Korean Medical Association appeared to become stronger. The Korean Medical Association gained experience of organising and politicising their organisation, which prior to this had had little political experience and organisational sense.

In the meantime, during the Election of President of Korea, the Korean Pharmaceutical Association employed a different strategy from the KMA's. In public, the Korean Pharmaceutical Association did not support a specific party, but divided their members and sent them out to both camps to support each of them, as interest groups would do. However, the executives of the Korean Pharmaceutical Association did not forget that the pharmacists' "true support" should go towards the liberal party in power. *Pharmacist3* described the real strategy of the time in pharmacy.

Though the whole mood of pharmacy was already inclined to Roh [Candidate of the liberal government party, Roh Mu-Hyun], we divided the executive members of the head office into two teams for the Election campaign. A few of the most important and active members were sent to Roh's camp [the liberal government party] as supporters. They took important positions there, such as the leader of the voluntary support group for Roh. At the same time, a large number of members went to Chang's camp [the conservative opposition party] and .. crowded there. We [the head office of the KPA] never expressed which side the KPA was on. We only strongly announced that every pharmacist should actively participate in the Presidential Election campaign, supporting 'whichever one sided with'. Anyway, the conservative opposition party was the first and the largest party in Korea. Even if it lost the Election, they would still have the strongest power in the National Assembly. We needed political insurance that would not make an enemy in politics. When Roh [Candidate of the liberal government party, Roh Mu-Hyun] won, we were really happy, but we did not express it. Then we made an announcement, "The Election is over. Let's return to our own work,

settling different political viewpoints and opinions amicably with each other”. (*Pharmacist3*)

The conflict over the separation system in health care and the Presidential Election of Korea in 2002 was a rare case in Korea, one in which professions and political ideology were prominently interrelated.

The conflict over the separation system developed into a political and ideological one that was different from Abbott’s cases and even from the former conflict between oriental medicine and pharmacy. As key leaders in medical associations commented, showing a certain political inclination was dangerous for an interest group. To survive, an interest group needed a good relationship with diverse influential parties. Exceptionally, however, the two medical professions, particularly western medicine, did reveal their specific political tendency in the conflict over the separation system. This conflict marked a turning point in which western medicine and pharmacy began to reveal their different political and ideological inclinations. In other words, the separation scheme was the trigger for a political and ideological collision between the two professions.

6.3 Organisational Capacity and Attitude of Western Medicine

6.3.1 Organisational Features and Capacity

During the open conflict with pharmacists, the Korean Medical Association (KMA) experienced fluctuation within its association and a change in organisational characteristics. One of the most prominent organisational features of the KMA during the conflict was the change of its leadership and the young generation’s coming into power. In November 1999, western physicians had their first and largest demonstration against the new repayment system, which caused the slump in western physicians’ benefits in every medical facility. 37,000 western physicians gathered in the JangChung Gymnasium to challenge the Government’s policy. The KMA executive and those western physicians present “were surprised and touched by the solidarity (*WesternPhysician03*)” of themselves.

Recognising their unity and being encouraged by the results of the first demonstration, young western physicians started voluntary actions. Led by the Democratic Physician Society through the internet, young western physicians “pushed” representatives of doctors to impeach the existing president and his executives in the General Meeting of Representatives of the Association held in January 2000. After

impeachment and dismissal of the president, young doctors stood with the executive of the KMA in joining the Combat Committee for the Rights of Doctors⁵³.

In 2001, as conflict between western medicine and pharmacy or the government got fiercer, Dr. Shin, the leader of the Combat Committee for the Rights of Doctors won the presidency of KMA in their first direct election⁵⁴. It was a prominent shift in generations within the leading group of western medicine, although western physicians were to change their president again from Dr. Shin back to their former president Dr. Kim in 2003.

The change of presidents in the KMA led to the change of its policy direction and to a degree of hardness when facing pharmacy and the government. In 2000, the appearance of president Dr. Kim meant that the then easy management style, which “mainly aimed to promote friendship between members (*Journalist1*)”, disappeared. In 2001, during the earlier period of Dr. Shin’s executive, he attempted a stronger fight with pharmacy and, particularly, with the government. In 2003, Dr. Kim’s reappearance as president of the KMA appeared to mean that western physicians preferred experienced and skilful leadership and policy to strong and harsh actions. It can be argued that during their conflict the KMA developed its organising, planning, staffing and coordinating.

From a certain viewpoint, the KMA’s internal fluctuation damaged its external influence and strategy.

What a repeated internal disorder.... That is why the KMA didn’t fully employ their tremendous influence and lobbying. If the KMA had used even 50% of their capacity, we would have been completely defeated. (*Pharmacist3*)

In addition, according to the pharmacists’ argument, internal disturbance in western medicine caused a slowing of the separation system. Because the executive had to gather support from their members, they “often broke a promise or an agreement (*Pharmacist3*)” with the government and/or pharmacy.

Flattering their members, executives of the KMA often went back on their promises. KMA leaders did not approach the separation system as a policy. Voting, surveying members’ opinions, demonstrating, and such

⁵³ Although the Combat Committee was a subsidiary group of the Korean Medical Association, its power preceded all other groups of medicine as the strife became severe (DongA.Com, 2000b).

⁵⁴ It was the first time to introduce a direct election system in medical professions in Korea. The Korean Pharmaceutical Association introduced a direct election system in 2003. The Association of Korean Oriental Medicine employs an indirect election system. Other important professions, such as Korean Bar Association, also use an indirect election system.

like that.... Many times the executives of the KMA agreed upon a plan at first but later changed their minds or denied the agreement (*Pharmacist3*).

Another outstanding point in the KMA leadership was the emergence of *the so-called 386 Generation*⁵⁵. *The 386 (Three-Eight-Six) Generation* means a generation of members who are in their 30s, studied in universities during the '80s and were born in the '60s. Members of this generation shared with each other a peculiar experience, culture and attitudes prevalent during the process of Korean democratisation in the 1980s.

We [younger doctors from *the 386 Generation*] established a few action groups on the internet first, such as the Meeting for Saving Small Clinics and the Democratic Physician Society. Then we activated the groups and started to mobilise other western physicians with our voluntary picketing demonstrations and putting ads in newspapers (*WesternPhysician03*).

After young western physicians joined the KMA, they mobilised medical students by “educating” the existing situations and the absurd medical system. Then, the Korean Intern Resident Association, which was composed of trainee doctors in every university hospital, was established and started to move. As trainee doctors began to act, medical professors backed and followed them.

6.3.2 Managerial and Political Capacity

Examining the KMA's, or western physicians', reaction to important medical schemes indicates their managerial and political capacity to deal with the conflict. Here, the western physicians' preparation for the separation system and their decision to stop a strike are presented as examples.

6.3.2.1 KMA's Preparation for the Separation System

When I asked western physicians how the executive or individual western physicians prepared in advance for the separation system, their answers were exactly the same: “nothing” and, then, they “really didn't know that the government really would do it”.

⁵⁵ In 1980s, Korean politics experienced upheavals that included another military coup d'état, fatal accidents by the military force, labour movements, demonstrations and a direct Presidential Election of Korea. It was a democratisation process. In the middle of the fluctuation, there were university students' movements. In 1980s, student movements in universities rapidly spread out to almost all students and were not limited to a specific small group. Under the situation, students experienced strong solidarity and learned organisational sense. The influence of the 386 Generation lead to more changes in every field of the country, especially after they became members of society with their own jobs. In every important social and political event and field, their leading and influence brought outstanding outcomes, such as national support in the World Cup 2002 and the dramatic reversion of the Presidential Election of Korea in 2002.

Even a few weeks before passing the revised Pharmaceutical Act at the National Assembly, most western physicians did not realise the impact of the separation system. Although a very few reform western physicians had argued that the separation system should be required and enforced and that western physicians should prepare for it, most western physicians did not believe that it would “really” take place. Because each government had included the enforcement of the separation system among its public pledges, but instead, only passed it to the next government, western physicians believed that this government would be the same. *Journalist1*, who understood western medicine, said,

Did you talk about any strategy for the separation system in advance [in western medicine]? Nothing. Totally nothing. Because under those complicated, damned, situations and circumstances, enforcement of the separation scheme was thought to be completely impossible. ... Before the war [the conflict over the separation system], the KMA was almost a social gathering for the old. There had never been organisational capacity in the KMA. Even if the existing KMA had wanted to prepare something, nothing could have been done with that kind of system and manpower. Anyway, western physicians never thought that the government would push it, that the pharmacists’ lobbying would work like that, or that reformists in the new government would have such a strong influence. Preparation? In advance? Never! (*Journalist1*)

Even a key leader of the KMA, *WesternPhysician03*, had not believed that the separation system would “really” be enforced in practice.

Physicians’ reactions to preparation for the separation scheme, such as “nothing” or “we absolutely didn’t know”, were totally different from those of pharmacists. Needless to say key leaders of pharmacy, even a pharmacist in a small city, *Pharmacist5*, had prepared for the separation system for a few years. This showed an example of how much western physicians had lacked any idea or sense about the government’s decision and policy. It also implied their weak point in gathering information and making a strategy for medical policy at that time.

6.3.2.2 ‘Impatient’ Decision on Stopping Strike?

One of the doctors’ most controversial actions during the conflict concerned the withdrawal of their biggest strike. This case showed the doctors’ tendency for policy-making.

In June 2000, they had a strike all over the country. On the 5th day, the President of Korea, Kim DaeJung, had a summit meeting with the leader of the opposition party, Lee Hoi-Chang. It was the first time in Korean history for a summit meeting in politics to

be held because of a medical issue. The leaders agreed that the political world would try to find a way out of the difficulty. Although there was no specific measure emerging from the summit meeting, western physicians believed that almost all was settled with the meeting itself and they hastened to withdraw their strike.

It was Saturday. In the 9pm news on TV, western physicians, who had staged a sit-down demonstration for a few days in the Korean Medical Association yard, were being photographed. Hurrah! They were cheering and shouting for joy. No! It's not! – I realised. It was a summit meeting. How urgent it was for the government! But the meeting was empty and insubstantial! Nevertheless, in western medicine, the argument for the withdrawal of the strike was carried on a swift current. You know, someday, we would have to withdraw the strike. Could it last for one year or one month? Even if we withdrew the strike, the form was highly important. You see, it was Saturday evening. If something specific came from government officials, it would be on Monday or Tuesday. We should also have set our actions by their schedule. We had a vote to decide if we would withdraw our strike or not. "Let's vote, OK, but not on Sunday. Let's announce the upcoming vote to western physicians on Monday, vote on Tuesday and withdraw on Wednesday!" We [the Combat Committee members] argued for this. But the thing was as good as settled to announce the vote on that very Saturday night, vote on Sunday and withdraw the strike at once. Then... as we had expected, after the withdrawal of the strike.... Why should the government hurry up? "OK, we'll do it. We're preparing now...." Just postponing everything with vague attitudes.... It was a critical moment for us. ... We should have been just a little slower (*WesternPhysician03*)

Believing only in an outline drawn by a political decision, western physicians stopped their action without an alternative. At that time, they might have felt heavy pressure from people's criticism and a sense of guilt from declining to help their patients. Western physicians appeared to be looking for justification to stop the strike. On the other hand, there might have been no other justification for delaying a withdrawal of the strike by western physicians. People believed that the summit meeting itself was the best political consideration for western physicians and that their actions were enough. However, from a strategic viewpoint only, the decision of medical professionals, to withdraw the strike appeared to be irrelevant. That was a turning point for western physicians. Although there were other actions after that, western physicians were not to make such a large-scale demonstration by themselves again.

Against the argument that the Korean Medical Association had few strategies and plans for facing the government and pharmacy, a key leader of the KMA, *WesternPhysician14*, resisted.

No strategy? That's only a minor, nonessential perspective. From the beginning, the government, pharmacy and civic groups were bound into one for the separation system. Under those circumstances, any discussion or any strategy was meaningless, needless, because they had already decided to enforce it. Such an argument is a trick to cover the essence of the problem. The fundamental reason why western physicians had to go out on strike had to be considered. Was it failure of the agreement? It was not. The separation system is a health care policy excluding western medicine, and the expression of 'social agreement' is just political propaganda. (*WesternPhysician14*)

Nevertheless, the Korean Medical Association could not avoid the criticism that they were negligent in considering change of circumstances for health care and preparing for the separation system.

6.3.2.3 Tackling Government: Physicians' Naïve Style of Lobbying

Among government officials and key leaders in other professions, western physicians were well known for their pride and their inexperienced and immature access to the political field and the government.

During the separation system, there was no systematic process for contacting government organisations in western medicine, such as existed in oriental medicine. The Korean Medical Association appeared to have little political or negotiation skill. The following examples show this.

Key leaders of the KMA at times paid a surprise visit to the Minister to demand something. When government officials received a sudden order from the Minister, they felt ... uncomfortable, backbiting 'your noble doctors'. Western medicine made a wrong move at every step. When Minister Cha visited the KMA, he heard ... harsh, terrible abuse in his presence from western physicians. It was difficult for his subordinates to bear their disgrace from doctor's insult. (*Pharmacist3*)

The KMA was surprisingly poor at establishing a good relationship with other groups [such as civic groups, the press or the government]. Health care in Korea had surely developed in response to people's demands, but only doctors didn't seem to change. (*CivicGroupLeader3*)

Western physicians? My goodness,... Who could stop western physicians? They are .. stubborn, authoritarian, yelling out if something is not perfect for them. It's really hard to make them understand some situation. (*GovernmentMember1*)

From this perspective above, it would be better to use the expression "tackling the government" than "persuading the government" when describing the western physicians' style of lobbying.

Why the medical profession showed a so-called “immature attitude to politics” can be explained from different viewpoints. Practically, until 1999 they had had few experiences of conflict with another group. Pharmacists and oriental doctors had already experienced their conflict in the early 1990s. Therefore, not only had the western physicians tried to organise themselves, they were not even interested in making networks either in or outside western medicine. This late start left western physicians inexperienced and unskilful when confronting the government and pharmacists. In addition, the doctors’ social position and professional pride had never prompted them to establish good relationships or cooperation with others.

The western physicians’ internal decision-making process appeared to become too democratised to be subtle and strategic. The Korean Medical Association had to report the progress of negotiations and other working processes to its members. It also had to obtain the members’ agreement at every important step. About “80,000 clever physicians had their own strong opinions and alternatives (*WesternPhysician13*)”. The open and speedy internet network and the Korean Medical Association local branches all over the country did not allow its executives to do anything in secret strategically or skilfully. This again influenced KMA’s attitude toward the government. In front of external conflict with the government and pharmacists, the executives had to struggle with internal demands for democratisation of the KMA. They had to be sensitive to the ranks’ opinions, collect them and reflect upon them in their decision-making. That may be another reason why the KMA had to reveal its every move and take an unstable course.

During the interviews, a few Korean Medical Association leaders regretted that, for the previous 30 years and by the end of the external conflict, the KMA had “hardly made any partnership with the government, regarding medical policy (*WesternPhysician10*)”. The KMA had had only a few experiences of joining or participating in public policies. An interviewee considered that “it was because western physicians absolutely believed the government”. However, even he reflected that they “should have become interested in health care policy in advance (*WesternPhysician13*)”.

6.3.3 Western Physicians’ Attitudes

Western physicians had a firm belief that they were the mainstream of health care and that their professional position and authority should never be threatened or challenged by any other group. During interviewing, western physicians used expressions, such as “a conductor in an orchestra” or “an absolute leader in the medical field” to indicate their views.

Western physicians and pharmacists are never equal. Of course they are equal from the perspective of human rights. However, in health care, pharmacists should follow the doctors' orders, which are unconditional. (*WesternPhysician13*)

During the medical disturbance from the separation system, one of the most important attitudes of western physicians, one which influenced their decision, was their professional pride and its perceived damage. Western physicians were displeased that the government and the people "compelled them to sacrifice their professional rights and financial benefits" without any consideration of their huge efforts and investment. Western physicians shared frustration and humiliation from the "absurd medical system and the government's sudden attack".

We should be respected, because western physicians deal with people's lives. Without trust in doctors, patients would not overcome their illnesses. ... The existence of a doctor itself is an important treatment (*WesternPhysician09*).

Western physicians felt cheated by the system and believed their social and economic expectations were threatened by the separation system. In particular, young western physicians were in a serious crisis.

Let's see. To enter a medical university, we studied deadly hard, particularly because of our damned strongly competitive training system. After being a medical student, there was another hell. Only half of my classmates graduated. Could passing a licence examination be easy? Opening a clinic requires a huge amount of money and we would have to follow every facility standard. Then, every medical facility would have to accept the National Health Insurance scheme. We would have no right to reject a patient. If a medical accident occurred, who would be responsible for it? Would it be a doctor's completely responsibility? And we don't have a right to collective action. What on earth are the benefits in return for being western physicians? Regardless of our hard time and efforts, now our society is emphasising only equal outcome and equal payment. Do you call such a society Utopia? Then, who would work and who would make an effort? We have some standard in our mind that I should or would get a return at a certain level. People will say it's ... haughtiness - but it's pride. Professional pride. Without such a pride, how could professionals keep their position? (*WesternPhysician03*)

All western physicians among the interviewees took considerable time during their interview to emphasise the structural contradiction in health care. Western physicians were deeply indignant that only they became the target of criticism without critics explaining the environmental and structural problems. *Journalist1* said,

However I point out the organisational contradictions in health care or the background of this chaos while interviewing on TV or other mass media, those parts are always curtailed. Whenever I watch a recorded program in which I was interviewed, I feel foolish. Well, I'm OK, but the important thing is that people don't understand the organisational contradictions. (*Journalist1*)

The most frequent and strongest argument on the structural problem was that western physicians had to do everything by themselves to survive in a market system, without any aid of the government. "Then the irresponsible government only tried to kill western physicians (*WesternPhysician03*)", according to interviewees.

In the core of western physicians' resistance, there was an emotional hurt and fury. Western physicians were hurt, because they were condemned as 'thieves'. They said:

One morning, we woke up to find ourselves called thieves. Then there followed a ruthless and sudden attack from civic groups, pharmacists, the government and the people. (*WesternPhysician10*)

From an objective viewpoint, *Journalist1* said,

"What did we do that was so wrong and evil?" Western physicians say that they're mortified at being mistreated. Mortified! "The margin? The government already knew and connived with it. Whenever western physicians asked to increase fees for medical services, the government denied it, because people would resist. Instead, the government suggested that we should eat more from the margins. Didn't they encourage western physicians to receive margins? Now the government pretends they didn't know anything about it, and imputes all fault to the western physicians." This point decisively makes western physicians furious (*Journalist1*).

For about three years after the disturbance, western physicians felt defeated. They appeared to be tired of either fighting or being blamed. They appeared to pass the critical moment, the Presidential Election of Korea in 2002, only to lose. The fact that they chose a "less hard" candidate as their new president of the Korean Medical Association in March 2003 implied that they were tired of severe conflict and wanted a different situation.

We were totally defeated. You might see [such a mood] during your interview. Who could be denounced? It was not a certain person's fault. Our [western physicians'] organisation or system did not deal well with

the whole situation and all of the members' demands.
(*WesternPhysician03*)

As shown above, western medicine was the last main medical profession to become involved in open conflict. Their internal reform attempted by young reformists was undergone in a most rapid way. A direct election system was introduced in the Korean Medical Association for the first time in the history of professions in Korea. The KMA's lack of experience in open conflict with other professions and their rapid internal reform brought western medicine a trial-and-error approach that included unskilful actions and unprepared strategies during the conflict. Organisational features and situations were not strong points in western medicine during this conflict with pharmacy. Western physicians' frustration and humiliation linked to their hard collective actions. The threat to their professionalism, from either the government or pharmacists, led to the western physicians' fury and to a feeling of professional crisis.

6.4 Organisational Capacity and Attitudes of Pharmacy

Fundamentally, pharmacy was standing at an advantageous point at the beginning of the separation system. The system was the government's promise, which was guaranteed when the pharmacists' first conflict with oriental medicine was settled. It was consistent with the pharmacists' wish to strengthen their professionalism, and they knew it would be enforced. It was not surprising that pharmacy prepared more for the separation system than did western medicine. Pharmacy also had strong points in their leadership and managerial and political capacity as presented below.

6.4.1 Leadership of Pharmacy

The Korean Pharmaceutical Association had already experienced its organisational reform in the head office during the earlier conflict with oriental medicine. After the *coup d'état* by young reformists, the Korean Pharmaceutical Association (KPA) developed a stable leadership. Therefore, during their second conflict with western medicine, the KPA showed strong leadership and skilful strategies. This organisational feature in pharmacy was a strong point compared with western medicine, which had only started its reform and experienced serious fluctuations in the executive.

When the separation system was set up, the existing president of the Korean Pharmaceutical Association, Kim H., was supported by young reformists in pharmacy. One of the most prominent reformist groups in pharmacy was the Korean Pharmacists for Democratic Society. It was established in 1990 by rallying other small regional groups

that had participated in the political democratic movements in the late 1980s⁵⁶. Although the number of members in the Korean Pharmacists for Democratic Society was less than 2% of all pharmacists, “this young power became influential in decision-making of the KPA (*Pharmacist3*)”.

The position and role of the Korean Pharmacists for Democratic Society can be compared with that of the reformist group in western medicine, the Association of Physicians for Humanism. Both had a common feature in that they were reformist groups within their own professions. In addition, they expressed their political opinions and participated in the political democratisation of Korea. Their active political expressions were exceptional in the medical professions, which had been traditionally indifferent to politics. In spite of these common points, two groups showed prominent differences from each other.

The Korean Pharmacists for Democratic Society joined the internal change in the head office of the Korean Pharmaceutical Association and attempted to reform their own profession first. Then, young reformists in pharmacy actively participated in policy-making in the KPA and supported their president and the head office. In contrast, by leading the enforcement of the separation scheme, the Association of Physicians for Humanism first attempted to reform the entire medical system, not their own profession. The Association of Physicians for Humanism did not attempt to persuade their colleagues, nor did they obtain any agreement or support from them. Therefore, unlike the Korean Pharmacists for Democratic Society, the Association of Physicians for Humanism went its separate way from the Korean Medical Association through the conflict over the separation system. As a result, they came to be seen as ‘the internal enemy’ by most western physicians.

I also found that the two reformist groups showed a subtle difference in their political lines, however liberal or progressive in politics they were. The origin of the Korean Pharmacists for Democratic Society was regional pharmacist groups, which were established to join the political demonstration in the late 1980s. At that time, the political movement for democratisation in Korea briefly spread out into all fields. Therefore, the political inclination of the Korean Pharmacists for Democratic Society, which was against dictatorship and for democratisation in Korea, was understandable and acceptable to most pharmacists and most people. On the contrary, the Association of Physicians for Humanism attempted to transform the whole health care system into a more socialist one

⁵⁶ In 1987, there were nation-wide political demonstrations to obtain a system for the Direct Korean Presidential Election. It was a historic occasion that allowed the entire population to participate in the political movement in Korea.

(pp. 130-131). Their political line was too radical to be accepted by most western physicians and people.

After successfully entering the head office of the Korean Pharmaceutical Association by their *coup d'état* with an acceptable liberal political value, Korean Pharmacists for Democratic Society came to be an influential group, who led and intervened in setting up the separation scheme in pharmacy. The young power appeared to strengthen the capacity and force of pharmacy in facing western physicians. They joined in persuading the ranks and forming the separation system in favour of pharmacy by supporting the president and the head office of the Korean Pharmaceutical Association.

6.4.2 Managerial Capacity

The leaders of pharmacy interviewed told me how they overcame some of their members' resistance and regained their trust. At the first stage of forming the separation system, some members in the low rank in pharmacy showed a resistance to and dissatisfaction with the new scheme. They were reluctant to lose their role as "small doctors". In addition, small pharmacies far from medical institutes were seriously damaged by the separation system.

At first, pharmacists strongly resisted the separation system and the attitude of the head office to the system. "I shall not live with them [the leaders of the Korean Pharmaceutical Association] under this sky!" The office of the president had been forcefully occupied by the resisters several times. "Who agreed with the separation system? Get out! What is the Association doing while pharmacists are dying?" Pharmacists fell into a huge panic. (*Pharmacist3*)

However, in spite of some members' resistance, there was no other *coup d'état* in the head office of the Korean Pharmaceutical Association. This implied that there was a specific and strong leading group in the Korean Pharmaceutical Association, one which was separate from the ranks and could not be encroached by them. Government officials from pharmacy with the best educational background and career had strong and skilful leadership.

We [KPA leaders] accepted the members' fury modestly. It was understandable and no wonder (*Pharmacist3*).

They did not react directly to the members' hard emotions, and the members did not appear to have any intention or capacity to change their leadership.

After several demonstrations against the Korean Pharmaceutical Association leadership, the members started to “completely ignore” the KPA’s decision-making and actions. Pharmacists “did not respond to any action of the KPA (*Pharmacist3*)”. I believe that their intentional neglect appeared to be rather helpful for the leaders of pharmacy, who had to negotiate with western medicine and cooperate with the government and civic groups. Unlike the Korean Medical Association, the KPA did not have to obtain internal agreement from their members in every negotiation with western medicine. Only after the separation system settled down did the leaders of pharmacy attempt to regain the trust of their members.

The leaders told me about their strategies to regain the members’ trust and support, which gave evidence of the managerial capacity of this leading group in pharmacy. The head office of the Korean Pharmaceutical Association did a rolling protest before the Ministry of Health and Welfare building to symbolise their concern about the overstock of medicines in pharmacies. The KPA also made the Standard Trade Contract applicable to pharmaceutical companies and wholesale dealers. The Standard Labour Contract for employed pharmacists in medium and large pharmacies was also recommended and made by the head office.

The KPA head office also prepared in advance an education program for pharmacists regarding the separation system. Before the separation system, the KPA made a computer program for the management of medicines and then provided lessons for all pharmacists who were employing the program. In that computer program for medicines, there was information about all kinds of medicines, disease, interaction between medicines, the relationship between medicines and foods and administering medicines.

An interviewee managing her pharmacy in a small city was pleased with the education program.

We prepared very hard for the separation system by taking the training for three months. I studied very hard, harder than when I was a student. Well, although there were some things too advanced to apply in practice, it was good. Without the training, I don’t know what I would have done under the new system (*Pharmacist5*).

After the separation system, pharmacists were generally satisfied with the KPA’s leadership and actions during the separation system.

Anyway, in enforcing the separation system and .. reaching the present situation, we owe the KPA and its leadership. Well responding to all

situations, generally. Through the conflict with oriental medicine, leaders and their ways of responding to situations had changed much, and it seemed to work during the next conflict with western physicians. It was well done, particularly compared with the first fight, I think. (*Pharmacist1*)

There appeared to be another reason why the KPA had strong organisational power. According to a leader of the KPA (*Pharmacist3*), 99% of pharmacists had reported individual specification to the KPA every year. This showed that pharmacists tended to comply well with the KPA. In addition, 62% of pharmacists were female (Ministry of Health and Welfare, 2001). Female pharmacists had professional pride in their occupation and high position as females in Korean society. This gender feature appeared to strengthen the solidarity of pharmacy.

6.4.3 Political Capacity

I was lucky to meet and interview “the self-appointed connector” between pharmacy and the government. His comments made it clear why pharmacy worked well in the government and political system. He described how they “persuaded” the government and the political system when setting up the separation system.

Other interest groups would not know the accurate contact points and pathways in the government and the political system, which are essential in lobbying. They might know whom they should contact, but that is not enough. Understanding the whole mechanism of decision-making is the most important. A meeting with an influential member of the National Assembly is not all. We should know how a bill is, before entering the National Assembly, examined and decided in other small groups, such as bureaus or offices. How is the bill weighed? How does it appeal to the Standing Committee of the National Assembly? What is the specific legal process to pass the National Assembly? What are the form and process of a petition? What about repetition? In every stage, the contact point and the logic to persuade a figure concerned are different. [We have already learned all those things.] Pharmacists have another strong point. A female pharmacist tends to get married with a man from a good family, making it is easy to find and reach an influential or a necessary figure.

Even the Minister of Health and Welfare cannot decide a big policy, such as the separation system, as he wishes. Support from lower government officials, not only from other influential political figures, is also essential in setting up a system. Government officials do not like a top-down order. The driving force in implementing a policy is much stronger, if the government official concerned understands it in advance, not through a one-way order from their senior, but by meeting with us. Someone should make and show accurate contact points in the administrative and political system, take the proper time to meet them and provide logic and data to persuade them. (*GovernmentMember3*)

The protocol of pharmacy for treating the government and the political system had an important similar point to that in oriental medicine. Pharmacy and oriental medicine considered the figures and lines around the key points in the government and the political field as important as the golden points. They “respectfully and cautiously” met and dealt with the government officials concerned, “individually gathering different information”. That was different from western medicine.

In fact, there was a point in the lobbying system of pharmacy that was different from oriental medicine and other professions. In setting up the separation system, pharmacy had “some figures” in the government, like the interviewee, who were well informed of the contact points, pathways and features in them. They came from pharmacy, having loyalty to their profession. It was the strongest resource of pharmacy in all health care.

The political capacity of pharmacy to handle the bureaucratic field was already well known after the first conflict. During the conflict with the separation system, they simultaneously used a hard and a soft approach as their strategy.

We strongly argued with government officials during discussions or debates – once we even overthrew a desk. One day, we were fighting with a high official for about 40 minutes in his office and his subordinates were concerned. ... While we took strong actions, we connected with all government officials through the line from the lower to the very person in charge. Actually, the working-level officials are the most important, aren't they? We never tried to push anything by displaying our power, and we didn't try to publish our actions – neither meeting officials nor anything else. (*Pharmacist3*)

As the liberal government party won the Korean Presidential Election in 2002, pharmacy, which took sides with it during the Election campaign, came to strengthen its political influence. The important persons in the health care field of the new government, such as Presidential aides or members of the President-elect Roh's Transition Committee⁵⁷, came from the leading group in enforcing the separation system. “Those influential persons were not unfamiliar with the KPA leaders (*Pharmacist3*)”. The key members in the new government and leaders of pharmacy already had a specific network between them.

⁵⁷ The Transition Committee to establish the regime had strong power. Leaders of the specific fields in the Transition Committee were the first candidates with key positions in the new government.

From an interview, I discerned another interesting point, which showed a diplomatic ability within pharmacy. To persuade influential persons in the government and the political system, pharmacists required financial data and academic papers. Ironically, according to an interviewee, it was a few academic members in western medicine who furnished pharmacy with those data and logics.

We needed something... from health care economics or health care sociology. We didn't have persons within pharmacy who had the academic background to deal with statistical data. Actually, there WERE a few pharmacists who could, but they belonged to the Korean Institute for Health and Social Affairs [the government research institution] and could not work for us. For them, researching for only one group would be fatal. So, .. you may not know, we borrowed brains for the work ... from... western medicine. Western physicians might hate us, but we have a communication line within western medicine (*GovernmentMember3*).

According to the interviewee, in 1999, when the enforcement of the separation system was delayed until the following year, pharmacy began to prepare an academic and financial paper as a basis for their argument. However, western medicine did not do the paper work, since they suffered from their own internal debates over the separation system. It is supposed that the foreign force might be the progressive medical academic members, who also established for the government the academic basis for the separation system. Given that the Korean Medical Association was criticised for its poor financial paper in a meeting to set up the separation system, the irony was all the greater.

The Korean Pharmaceutical Association had another prominent point in dealing with civil pressure groups and the government.

After their first conflict with oriental medicine, pharmacists seemed to recognise the importance of their relationship with other groups in society. Their ways of responding to the press, civil pressure groups and people were far more refined than western medicines. (*CivicGroupLeader3*)

With the beginning of the separation system, the leaders in pharmacy strove to clean-up their own house. That was not only an ethical requirement, but also their political strategy to obtain support from civil pressure groups and the government. For example, the head office of the Korean Pharmaceutical Association recommended and then forced their members to pay for medicines with credit cards, not cash, in order to eradicate 'black rebate' from pharmaceutical companies. The head office let pharmacies accuse pharmaceutical companies that rejected credit cards. The illegal rebates were

coming from an obscure and negative circulation system of medicines, in which pharmaceutical companies could make illicit profits, because a flow of cash had not been captured. Although payment by credit cards was required for clear and fair trade of medicines, pharmacists resisted giving up their illicit profits, which had been as a result of accepting credit cards. This became another burden for the leaders in pharmacy. Nevertheless, they forced the clear payment system by credit cards.

We need something for dealing with the government. ... “Look! We try to clear the black margin by ourselves. Because of it, pharmacists are suffering from immediate financial difficulties. Don’t you see the ranks resist us [the head office of the Korean Pharmaceutical Association] and our scheme for self-purification? Nevertheless, we are doing it. So... this is your turn. What will you [civil pressure groups or the government] do for us? Don’t you think that you should give us SOMETHING?” We had a right to request from them [civil pressure groups or the government] something in terms of self-purification. (*Pharmacist3*)

At that time, one of the most important tasks for the government was eradicating corruption and irregularities in society. Civil pressure groups, which were the main supporters of the government, also focused their efforts on the issue. Under these situations, the KPA’s efforts for self-purification were consistent with the policy of the government and the civil pressure groups. Therefore, in my opinion, the government and the civil pressure groups could not deny their support to pharmacy. In contrast, western medicine strongly resisted eradicating *the margin* without full compensation for it within a distorted medical system. From the viewpoint of the government and civil pressure groups, western medicine did not attempt anything for their self-purification, although it had “a bigger corrupted part” than pharmacy. These different attitudes and activities of the two professions were certainly compared with each other by the government and civic groups. Strategically and politically, the head office of the Korean Pharmaceutical Association was earning higher marks than the executive of the Korean Medical Association.

6.4.4 Pharmacists’ Attitudes

The comments from leaders in pharmacy showed that their wish for the separation system came from their professional identity crisis. They said that the separation system was their last opportunity “to be the true profession of medicines (*Pharmacist3*)”. Pharmacists did not want to be considered as only clerks in pharmacies. With the motivation to be true professionals, even members in the low rank prepared for the separation system, realising its importance.

For a long time I had prepared many things for the separation system, before it started. I looked for and decided on a location... At first, I tried to invest in a new large clinic complex at a certain portion and enter it, but that was not permitted, and .. I had to change my plan. Therefore, I settled down at the present location [beside the complex]. I also devised in advance the internal structure and interior decoration of my pharmacy and ... (*Pharmacist5*)

Although it was said to be a rare case, that pharmacist's experience showed how the separation system appealed to pharmacists generally.

Pharmacists did not show as much anxiety as western physicians did about the separation system. One reason may be that pharmacists accepted the separation system from the beginning. However, they felt unpleasant after the separation system settled down.

As the separation system entered a stable phase, there emerged a subordinate relationship between western physicians and pharmacists in neighbouring medical facilities.

We [pharmacists] should try to make a good relationship with the western physicians in clinics or nearby hospitals (*Pharmacists1; Pharmacist5*).

If the western physicians often changed medicines in their prescriptions without considering the pharmacies in the neighbourhood, the pharmacists would face financial difficulties in managing their pharmacies. Therefore, according to the interviewees, some pharmacists used to give a "gift" to western physicians in the neighbourhood on a particular day such as New Year's Day. This situation made pharmacists feel subordinate to western physicians.

Now, the decisions of clinics and hospitals influence pharmacies at hand. I wish they would consider our situations, but... Our pride also is hurt. It's a completely dependent relationship (*Pharmacist1*).

Now? We only have to follow doctors' prescriptions. If we protest a prescription by asking, ...western physicians show displeasure. I am an owner [with three subordinate pharmacists], so I'd like to just pass without any conflict. However, a pharmacist with a strong pride quarrels with such a western physician. (*Pharmacist5*)

Pharmacists have deep-rooted displeasure at having a subordinate relationship with western physicians. An interviewee's experience told an example of such a relationship.

As soon as I graduated from the university, I took a job in a general hospital and became interested in clinical pharmacy. In the US, there's such a system. To give a better medical service to patients, western physicians, pharmacists and nurses form a team, as fellows, discussing with each other. I dreamt of such a relationship and position, but.. it was a totally shattered illusion ... while working in the hospital. I realised exactly what the position of a pharmacist is to western physicians. (*Pharmacist1*).

The whole medical system in our country is still patriarchal. Orders from western physicians are only one-way. No discussion. I wish all members in health care - western physicians, nurses, pharmacists, and medical technicians - would be a team. I don't deny that a western physician is the eldest brother, but when a western physician prescribes medicines for a patient, I wish he would first consult and discuss it with a pharmacist. (*GovernmentMember3*)

Pharmacists' feeling of humiliation from a subordinate relationship and their efforts to overcome it push them to devise new schemes or actions for the future. The conflictual relationship between pharmacy and western medicine will not easily come to an end.

As shown above, in this second conflict with competitors, pharmacy showed better-organised and skilful management in facing western medicine. Leadership in pharmacy was more stable than it had been during their first conflict with oriental medicine and more prepared than leadership in western medicine. To effectively persuade their members and obtain support from them, the leaders of pharmacy attempted several programmes and strategies. The political capacity of pharmacy was also successful, in part because pharmacists still had supporters within the government as they had had during their first conflict with oriental medicine. At the same time, they also won support from civic pressure groups and the public, which they had lost during their first conflict. As presented in their attitude, pharmacists' wish to be a true professional and to be a member of a team with western physicians in health care was an important force to lead the separation system.

6.5 Government and Other Environmental Factors

6.5.1 Role of the Government

6.5.1.1 Ministry of Health and Welfare and Intervention of Top Political Field

The government often changed its directions in leading the separation system. During 1999 to 2002, five Ministers of Health and Welfare came and went with regard to the enforcement of the separation scheme. Whenever a Minister changed, the government's approach to the separation system also changed. *Pharmacist3*, one leader in pharmacy, looked back on the situation at the time.

Minister Cha (May 1999 to Aug 2000) had been a reformist scholar in health care, particularly, in the National Health Insurance. He was the first Minister, who started the separation system. He mapped out the separation scheme based on academic ideals and he pushed the separation system with his strong will and drive. By implementing this 'strange' scheme, he was criticised by both medical professions. As western physicians started their resistance with large-scale demonstrations, the government attempted to solve the complicated situations by appointing Minister Choi (Aug 2000 to Mar 2001), who was of a bureaucratic origin. As he had done in his former position⁵⁸ as Minister of Labour, he established and led the Conference of Medicine, Pharmacy and the Government.

The third minister, Kim, had a strong political influence, which was needed in attempts to improve the frozen relationship among western physicians, pharmacists and the government. The next leader, Minister Lee, focused on the issue of eradicating irregularities and corruption in the health care system while enforcing the separation system. Under the pressure of financial difficulties in the National Health Insurance, his main task was curtailing the fee for medical services and for the price of medicines in the National Health Insurance.

As shown above, the government had changed the Ministers of Health and Welfare from one of academic origin to one with a political influence. The government attempted to adapt its policy to changing circumstances by replacing Ministers. However, the evaluation that "the government lost its principle and conviction (*Pharmacist3*)" could not be denied. Most of all, the government lost control of the new scheme and of the professions. Then, they had to hand their initiative over to the political area. A government official commented on the turning point as follows:

Over the separation system, the Ministry of Health and Welfare lost its initiative. Decisively, with the 6.24 Conference [over the separation system and the western physicians' strike] between the Korean President

⁵⁸ When Minister Choi took charge of the Ministry of Labour, he made and led the Conference of Labour-Management-Government to arrange the relationship between labour and management.

and the leader of the first opposition party, the policy [the separation system] left the hands of Ministry of Health and Welfare and entered the political field. After that, the Ministry of Health and Welfare was engrossed only in appeasing western physicians and assembling the existing policy, political alternatives and other parts to make grounds for the separation system... (*GovernmentMember1*)

A figure in the political field, who was well informed of the existing situations, revealed that, at that time, a task force for the separation system was established in the Office of the President (of Korea). He explained more about why the core of politics intervened in the conflict.

It was unofficial and ... few people knew it. The Ministry of Health and Welfare should have arranged all things concerned, but they couldn't. Then the Office of the President took over the work. At first, the Senior Secretary to the President for Welfare Policy in the Office of the President took charge in it, but soon it transferred again to the Senior Secretary to the President for Policy and Planning in the Office of the President. The task force operated under the control of him. Control of the Ministry of Health and Welfare was not mature, and the situations were too complicated and too sensitive for the Ministry of Health and Welfare to control them. The strategy, such as taking advantage of the internal conflict in western medicine and breaking up its capacity to small parts, might have needed, but there was no strategy in the MOHW. ... So, the situation was too big to expect something from government officials. Even the existing Ministers lacked capacity and preparation to lead the situation. They just ... simply thought that only an increase in the medical fee would be OK for western physicians. As a result, they lost control of the separation system. In the end, the task force took all control over settling down the system. (*GovernmentMember2*)

However, even the intervention of high politics in the conflict could not control all situations.

The government was not strong enough to control and lead the new system, because the opposition party occupied the majority in the National Assembly. (*GovernmentMember2*)

At the same time, having political control over the separation system brought government officials difficulties and displeasure. Although they could not externally resist their superiors within the political system, they felt frustrated. Another government official's comment on the situation:

In fact, the Office of the President instructed almost all of us about the separation system, but all the blame was shifted onto us [government officials in Ministry of Health and Welfare]. A high government official

responsible for the separation system took a strong disciplinary action. At that time, the Public Prosecutors Office tried to summon a political figure, a former Minister, in order to investigate the process of setting up the separation system. However, as the former Minister responded that he would reveal everything, the Public Prosecutors Office gave up his summons. Then only the government officials concerned suffered disciplinary actions. Because of that, many government officials were enraged and felt frustrated. (*GovernmentMember4*)

Although the government and the political system experienced their own difficulties, the relationship between the government and the professions went on in a consistent way. Based on the interviewees' comments, the relationship between the government and western medicine had been one full of troubles, while that between the government and pharmacy had been always open to compromise and understanding.

Distrust between them often blocked forming and enforcing the separation scheme. *Pharmacist3* reported that the government and pharmacy could not trust the western physicians' decisions any more, since "the KMA had always upset agreements or promises already made (*Pharmacist3*)".

However, from the perspective of western medicine, the government only 'pushed' western medicine to follow the separation system, "considering the KMA as a subordinate institution", not as a partner in policy. This style of government leadership caused the western physicians' strong resistance.

The government considered western physicians only as an objective to reform. "You already have enough. So, take out yours, now!" Excluding the main player, they tried to make us act in a fixed way. (*WesternPhysician14*)

Even pharmacy admitted that there had been problems with the government's attitude toward western physicians.

The government tried to control even the number of pills and regulated the amount of injection medicine in one prescription. Those specifications would be kept voluntarily by western physicians. In deciding and implementing medical policy, the western physicians' role and their cooperation is important. So, it is necessary for the government to induce western physicians to join the process of policy, not to pull them by force. (*Pharmacist3*)

The attitude of the Health Insurance Review Agency (HIRA) was reported as an example of the government's misleading of western medicine. The HIRA examines medical facilities' claims of payment in the National Health Insurance scheme. The main

role of the HIRA is to cut western physicians' claims and payments. The HIRA is said to incur resentment among western physicians because of their lack of standards and rationality in the way they cut. In addition, most examiners of the Agency are ex-nurses. Western physicians' humiliation and distrust of the Review Agency "has built up over ten years (*Pharmacist3*)".

Now, the attitude of the new government advisors toward western medicine is said to be different from that of the last government. Reformists in the last government believed that they should "compulsively beat, smash and drive western physicians (*Journalist1*)". However, advisors and government officials in the new government realised that they needed to soothe the western physicians and work together and that the most important thing in medical policy was the western physicians' voluntary cooperation. Nevertheless, the new President was said to "still have a strong distrust and dislike of western physicians (*Journalist1; OrientalDoctor4*)".

Contrary to the case of western medicine, all interviewees agreed that the government was more open to pharmacy, as shown in the following western physicians' quote.

The Ministry of Health and Welfare is the Ministry of Health and Pharmacy. (*WesternPhysician05*)

One reason for "the good relationship" between the government and pharmacy related to the personnel factor. As western physicians always complained, government officials with a background in pharmacy were "reinforcements for pharmacy" when enforcing the separation system. A more important reason was that the basis of the separation system was consistent with the direction of long-term policy in pharmacy. The skilful tactics of pharmacy toward the government would also be of help to pharmacy. Although there were cases where the government and pharmacy were in conflict with each other, both were patient enough to reach agreements.

6.5.1.2 Debate on the Government' Role

Although the government might have had its own excuse for the conflict, they revealed limits of capacity in managing the separation system. The following comments from representatives of civic pressure groups described the government's role and their problems. It is helpful to judge the government during the conflict over the separation system.

One problem was said to originate in the government's attitude toward interest groups. The government had believed that medical professions should and would only follow the government's decision and policy. From this perspective, the western physicians' demonstration and strike were unexpected, and the government became perplexed about how to manage the situation.

The government was ... still obsessed with their old paradigm. Although society had changed since the Korean Democratisation in the 1980s, bureaucrats had not. Even DJ[the then Korean President Kim DaeJung]'s welfare policy became politicised and let the players concerned face each other and try to negotiate with each other. Only the Ministry of Health and Welfare [the government] remained naïve on one-way of thinking. They never imagined a western physicians' strike. They [the government] should have studied and understood the medical professions and tried to persuade them. (*CivicGroupLeader3*)

In addition, the government was not familiar with accepting or considering a plan or a consensus led by private groups. The civic representatives submitted the first agreement on the separation system between western medicine and pharmacy, the 5.10 Agreement, to the government. However, while making specifications to enforce the separation system, the government could not overcome its own bureaucratic process and style.

Since the government had not joined the process of the 5.10 Agreement, they did not fully understand the original purpose, meaning and basic assumptions of the negotiation, and the bureaucratic process damaged them. We [the civic pressure groups] should have gone together with the government in making the specifications for it [the separation scheme]. You know, we [Koreans] are weak at designing a process. At the end of the year [1999], everything was shattered, and every player was damaged. Only the tattered system [the separation scheme] remained, losing its owner. (*CivicGroupLeader3*)

A civic leader, one of five representatives of civil pressure groups who helped set up the separation system, pointed out another problem in the government: there was no financial plan for the separation system.

The separation system required a specific budget, which should have been made in terms of an agreement between the political parties. The Minister of Health and Welfare, the Ministry of Finance and Economy, the Ministry of Planning and Budget were involved in preparing the budget. However, the Ministry of Planning and Budget had no right to arrange policies, and the Ministry of Finance and Economy didn't allocate a budget for the separation system. The Ministry of Health and

Welfare had difficulty enforcing the system without money. The Ministry of Health and Welfare was given a minimal budget, but only for the start of the scheme, not as a long-term budget (*CivicGroupLeader3*).

Based on the situations of the government and their problems commented on above, I basically refer now to the position and function of the government during the conflict. First of all, the government did not approach the separation system with a prepared overall plan. It focused on the relationships between the professions from a short-term perspective. There was considerable evidence among comments from interviewees that the government had neither a specific plan nor advance preparation for the separation system. This is why their control was taken by civic pressure groups and external reformists at the beginning stage and then by the top political field at the mid stage. As the conflict became more severe, the government attempted to appease only individual professions, leaving the new system itself lost.

Second, the fact that the players who devised the separation system within the government came from pharmacy was another fundamental limit when enforcing the system. However they attempted to be neutral, and however “they focused their efforts on compensating western physicians for their loss (*GovernmentMember3*)”, the purpose and the direction of the new scheme did not appeal to western physicians. Most of all, the original position of the devisers brought western physicians the distrust of the whole government and the separation system itself.

Third, there was no coordinator or major axis in the government or in the political system to enforce the separation system, who could control the situations and bridge all concerned departments and fields. Frequent changes of Ministers and controllers made the situation confused.

6.5.2 Role of Civil Pressure Groups

The appearance of civil pressure groups was *political*, since the idea of joining them was proposed by Dr. Kim YongIk, a key leader of the separation system. Civic groups emerged as follows. According to the Pharmaceutical Act amended in 1994 during the conflict between pharmacy and oriental medicine, the separation scheme in western medicine would be enforced by July 1999. However, western physicians and pharmacists wanted to postpone it until 2000. Both professions argued that they were still unprepared. While discussing postponement of the separation system, the provision that civil pressure groups should join in setting up the scheme was inserted in the process regulation.

Even the government party intervened between western medicine and pharmacy to make an agreement before, but they failed. Therefore, civil pressure groups were

considered the last arbitrator and expected to make an agreement between western medicine and pharmacy (Won, 2003: 69-70). Dr. Kim, who wrote the controversial article, “I Didn’t Train My Students to be Thieves”, was the promoter of the provision. He had already had an important position in civic movements. Considering this situation, there appeared to be a problem from the beginning with the role and the position of civil pressure groups as “the last arbitrator”.

In fact, according to a representative of the civic groups in the 5.10 Agreement (*CivicGroupLeader3*), there was a controversy among the civic pressure group leaders, kept hidden by those involved though, over their position in setting the separation system. One part insisted that the civic pressure group did not need to be an arbitrator, even if the separation system could not be enforced. Based on the original identity of the civic group, they argued that they only could reveal the problems in western medicine such as the *margin*, which people did not recognise. The other part argued that enforcement of the separation system could not be postponed any longer, and the civic group should actively intervene in the situations and arbitrate between western medicine and pharmacy to enforce the system.

The two perspectives originated from different assumptions about the level of medical fees in the National Health Insurance. Civic leaders with the latter perspective recognised that the level of medical fees in the NHI was unreasonably low. Their viewpoint implied that the separation system would be enforced with increasing the medical fee in the NHI. However, the civic representatives with the former perspective did not think that the level of medical fees was low. According to them, because there was no reliable data about the western physicians’ income level, no one could estimate the effect of an increase in medical fees in the NHI. These different opinions on the level of medical fees in the NHI led the civic representatives to different actions with each other while they designed the 5.10 Agreement.

At the beginning of setting the separation scheme, the perspective of being an arbitrator was dominant in civic groups. In 1999, the 5.10 Agreement on the separation system between western medicine and pharmacy was narrowly reached. However, in a few months, it broke with western physicians’ objection.

As western physicians started their strike, we [civil pressure groups] had to change our position from acting as arbitrators to attacking western physicians. Although a few leaders argued that we should still hold our neutral position as arbitrators, the general current in civic pressure groups moved to attack western medicine at once. (*CivicGroupLeader3*)

Civic pressure groups began to criticise all the arguments of western medicine. Their basic perspective was that western physicians did not have any right to say anything, because they were the source of the problem in health care.

All western physicians interviewed regarded civic groups as agents for the government “to kill”, that is to seriously damage, all western physicians. In fact, according to *OrientalDoctor4*, the government backed civil pressure groups by giving financial support and increasing the number of members, which later provoked severe criticism within and outside the civic movement. Western physicians were characterising civic groups as being like ‘the Red Guards’⁵⁹ in the Cultural Revolution in China, those who had led the destruction of the traditional culture and the propertied class.

They [civic groups] were the advance guard. Why did the government give money, 400 million Won [£ 200,000], to the People’s Solidarity for Participatory in the name of the budget for public relations of the separation system? How unreasonable! (*WesternPhysician10*)

Immature and cautiousless amateurism [of civic groups] ruined all things. (*WesternPhysician11*)

Some leaders of civil pressure groups also remarked that they were not ready to be a leading group or arbitrators in setting up the new health care system. They reflected their attitude and actions during the process of setting up the separation system as below.

There was no base. Even the civic movement itself had a short history [in Korea]. Only with the beginning of the 1990s, it started. In addition, health care was a completely professional field. Civic groups, no, even our society, had few discussions or debates on health care. Only after the event [the separation system] occurred, we [civic groups] hastened to study it and to function as arbitrators between western medicine and pharmacy at the same time. It was difficult, of course, but we did. You know, we Koreans live in a flying society, but ... we started to see many problems in our actions. We were not mature, not skilful, in dealing with such a huge policy (*CivicGroupLeader2*).

The most important flaw was said to be the change of their positions from arbitrators in the medical conflict into attackers of western medicine. When the conflict became fierce, they “had nothing to do but criticise western physicians (*CivicGroupLeader2*)” for their poor morality. They lost their neutrality and objectivity and were blamed for sticking to the government.

⁵⁹ Since the mid-presidency of President Kim DaeJung, civil pressure groups had been already criticised with this expression, not only in the medical field.

We.. somewhat.. yes, regret that, at that time, we were too much on the government's side... (*CivicGroupLeader3*)

With regard to the civic groups' attitudes, some government officials were not pleased either. A government official asserted:

They [civic groups] were ... irresponsible. They opposed something only for opposition. They made things messy and then went away. Making a certain group a target was their best strategy (*GovernmentMember4*).

One interviewee also regretted that they should have criticised western physicians for their fundamental role in Korean health care and their attitude to other medical assistance groups, not for their strike, which was a side issue.

The attack objective was wrong. Any group could have a strike. A western physicians' strike was not easy to criticise, though neither was it highly persuasive. Instead, we should have blamed them for their monopolistic and greedy jurisdiction or their authoritarian and arrogant attitude toward other medical assistants and patients. (*CivicGroupLeader2*)

As shown in the interviewees' comments above, the separation system was an important chance for civic groups to develop their influence and expand their movements. In fact, they showed strong political influence during the conflict with the support of the government⁶⁰. However, they were too political to keep their objectivity and fairness, although they made an agreement at the first stage. Now they are said to start a civic movement in health care again from the beginning point, in terms of small actions on small individual issues in order to make health care issues popular among the grassroots.

6.5.3 The Press and Public Opinion

During the conflict over the separation system, public opinion consistently went against western physicians. The first reason was that people had not known about the existence of illicit margins. "That brought a feeling of being betrayed to people (*Journalist2*)", who had paid a contribution for the NHI. The second reason was that western physicians took strong large-scale actions, such as strike and demonstrations, while resisting the government and the separation scheme. These collective actions by western physicians provoked people to fury, particularly patients and their families.

⁶⁰ Existing studies tend to set a high value on civic groups' role during the conflict over the separation system (Ahn, 2001; Ahn, 2002a, Cho, 2001).

Through their strikes, western physicians lost too much. In particular, traditional and fundamental respect for western physicians completely disappeared. In the past, people had called western physicians, 'Sir', 'Sir', with sincere respect. But now.. (*CivicGroupLeader4*)

People criticised only western physicians, not pharmacists. During their strike, some patients died, you know. At that time, we didn't have a strike. We had learned how much we had been blamed because of our strike during the first fight with oriental doctors. Since that time [western physicians' strike], the conflict emerged between western physicians and the government, not us. Owing to it, we could avoid direct blame during the conflict (*Pharmacist1*).

When the Korean Medical Association declared that they would strike again against the government's policy, the Korean Pharmaceutical Association responded that they would see patients and prescribe medicines instead of western physicians. The Korean Pharmaceutical Association took full advantage of their former experience with regard to the strike and avoided people's criticism.

Western physicians attempted to persuade people in terms of ads in the press that explained "the true and inevitable situations with regard to margins" and other controversial issues. However, those stories were too long and too complicated to attract people's attention.

People didn't try to give attention to deep and complex stories about individual medical issues. People began to hate the medical conflict or the separation system, as they disliked politics (*Journalist2*).

Now patients look at western physicians as if we were thieves. ... What is this? Can any proper practice be done? (*WesternPhysician10*)

The western physicians interviewed knew this social mood well, felt frustrated, and did not conceal their pained feelings. They felt sorry that people misunderstood the whole truth because of "an ill-intentioned strategy" by the government, civil pressure groups and the press to damage western physicians. According to western physicians, the government and the press intentionally divulged the margin and the most severe cases of it to create a black image of western medicine, although it had been an inevitable outcome of the organisational contradiction in the Korean medical system and the cases were only 1-2% of all western physicians. Since then, western medicine has been seen as blameworthy and among the most corrupt occupations.

WesternPhysician10, a member of the Combat Committee in the Korean Medical Association, argued that "there had been a guiding principle to control news items" over the separation system, one which had been sent from the Office of the President to the

press. On one hand, his comment implied that the government cornered western medicine in terms of the press in order to enforce the separation system. On the other hand, it showed doctors' distrust of the press and the government.

I asked *Journalist2* whether there had been any inclination against western medicine when sending out news or comments during the conflict. According to him, there had been no particular confidential order or principle in the press to take sides with or against any player during the conflict.

The argument that the government intended to kill western physicians [to enforce the separation system]...? It can be exaggerated. However, after western medicine strongly objected to the separation system, it was sure that the government identified the western medicine as a vested and conservative group to reform. The government did not appear to have any purpose against western medicine in the beginning. (*Journalist2*)

The interviewee had a liberal political perspective and was known as an activist for fair broadcasting. Considering his position, he did not have any intention of being on the government's side. However, according to his comment, although there was no order from the government to the press, the government did not have a favourable perspective on western medicine as the conflict developed. This might indirectly influence the press. With regard to the possibility of manipulation of public opinion by the press, the new president of the Korean Pharmaceutical Association gives a comment in his book.

A journalist confessed that the press had lost objectivity in publishing news and articles by being swept by some opinions of civil pressure groups and public opinion (Won, 2003: 73).

An influential civic representative agreed that the government employed the press to harm the western physicians' public image.

It was natural that the government tried to corner western physicians by using the press. Making a target group an attack objective would help the government to solve a problem more easily (*CivicGroupLeader4*).

Another representative of a civic group said that the damage to the doctors' image was neither from civic groups' instigation nor from the government' strategy, but from "people's mature consciousness".

People are not gullible any more to the press or any instigation of a particular group. Time has changed. People's consciousness has rapidly developed. I believe there already existed a huge current, grandly to

say, .. historical consciousness against monopolistic western physicians.
(*CivicGroupLeader2*)

According to the comments above, it was not easy to identify whether the origin of unfavourable opinions of western medicine was the government, civic groups, the press or people's consciousness. In any case, western physicians were seriously damaged by public opinion, and 'it would take a long time to recover trust' between western physicians and patients in Korean society (*WesternPhysician13*).

6.6 Interpretation of the Conflict

6.6.1. Implications of the Conflict

The second case of professional conflict in Korean health care was more complex than the first example and offers some interesting challenges to Abbott's (1988) model. It had more complicated causes and was related to more active factors. The conflict between western medicine and pharmacy over the separation system was another example of jurisdictional conflict that Abbott suggested. Over the right to prescribe medicines and the right to prepare and sell medicines, the most influential professions in Korean health care collided with each other. The fact that two critical jurisdictions and the two most important professions were involved in the conflict made the situation more complicated.

Because those jurisdictions were linked to financial benefits, the conflict developed into a more confused form. Monetary interests of professions in this case were more outstanding than any other conflictual cases in Korean health care. In addition, different from the first conflict in Korean health care and from Abbott's cases, this conflict showed a characteristic of political ideological strife. Therefore, this case showed more complex and more diverse characteristics and motivations than any of the other three Korean cases.

Reconsidering Abbott's Concept of Professional Jurisdiction

In the conflict over the separation system, Abbott's concept of jurisdiction needed to be refined and specified. Abbott's concept of jurisdiction is general and simple: the link between a profession and its work. There are few specific explanations or characteristics about jurisdiction in Abbott's work, although it is the key notion and the starting point of his study. According to him, the strength and weakness of the tie will be established in the processes of actual professional work. Since none of these links is absolute and permanent, the professions make up an interacting system. Then, Abbott developed his main topic into the system of professions, ignoring other additional explanations.

The second Korean case, however, contained the two dimensions of jurisdiction that operated simultaneously. One was whether or not a profession had a right to manage a certain professional field. Here, the point was a scope or an arena of work. The other was about whether or not the right of the field could be exclusive to other professions. Here, the point was the degree of possession of the field. Abbott did not divide the concept on jurisdiction into these sub-elements. The Korean case over the separation system showed how these two separate dimensions of jurisdiction made the conflict more complicated.

Before the separation system, western physicians and pharmacists could prescribe and dispense medicines at the same time. Although there was a fundamental difference between the two professions regarding the professional levels in seeing patients, western physicians in their own clinics and pharmacists had played almost the same role in practising medicine with non-acute patients. In this case, the two professions had shared the most important two fields with each other, not monopolistically occupying them. Figure 6-1 shows the controversial jurisdictions before the separation system.

Figure 6-1 Sharing Jurisdictions Before the Separation System

Professions	Western Physicians	Pharmacists
Professional Field	Prescribing medicines	Preparing medicines
Degree of Possession	Very Low	Very Low

However, according to the official concept of the separation system, only western physicians could/should prescribe medicines (as ① in Figure 6-2) and only pharmacists could/should prepare them (as ② in Figure 6-2). In this case, both professions would individually occupy a limited professional field with a monopolistic right. Figure 6-2 shows the concept and the intention of the separation system with regard to jurisdiction.

Figure 6-2 Concept of the Separation System

Professions	Western Physicians	Pharmacists
Professional Field	① ↓ Prescribing medicines	② ↓ Preparing medicines
Degree of Possession	Very High (Monopolistic)	Very High (Monopolistic)

However, western physicians did not believe the official meaning of the separation system. Instead, they believed that, under the existing circumstances, pharmacists would still prepare medicines with a great deal of discretion (as ③ in Figure 6-3). According to them, this meant that pharmacists would invade western physicians' jurisdiction, prescribing medicines and then seeing patients, while western physicians would not have access to preparing medicines. Figure 6-3 shows western physicians' understanding about the 'true meaning' of the separation system.

Figure 6-3 Western Physicians' Understanding about the Separation System

Professions	Western Physicians	Pharmacists
Professional Field	Prescribing medicines ① ↓	Preparing medicines ② ↓
Degree of Possession	Middle	Very High (Monopolistic)

Diagrammatic elements: A dashed vertical line separates the two columns. An arrow labeled ③ points from the 'Preparing medicines' field of Pharmacists to the 'Prescribing medicines' field of Western Physicians.

Therefore, western medicine suggested and still argues for an alternative, the Optional Separation System, not the complete separation scheme. In the optional separation scheme, patients can receive their medicines either in a clinic, where the prescription is issued, or in a pharmacy. It will be the patients' personal choice. Only in the former case, the patient pays more. In this case, the arena of preparing medicines will open again to western physicians (as ④ in Figure 6-4) and pharmacists will lose their monopoly of the field. Figure 6-4 represents this. In addition, western medicine wanted to prohibit pharmacists from seeing practising medicine as within their discretion, by attempting to diminish the scope of substitution medicines. In this case, pharmacists' invasion (as ③ in Figure 6-3) would be absorbed not to be revealed in Figure 6-4.

Figure 6-4 Optional Separation System Suggested by Western Medicine

Professions	Western Physicians	Pharmacists
Professional Field	Prescribing medicines ① ↓	Preparing medicines ② ↓
Degree of Possession	Very High (Monopolistic)	Middle (Patients' Choice)

Diagrammatic elements: A dashed vertical line separates the two columns. An arrow labeled ④ points from the 'Prescribing medicines' field of Western Physicians to the 'Preparing medicines' field of Pharmacists.

As shown above, Abbott's concept of professional jurisdiction was too general to explain the conflict over the separation system in Korea. If there was only one controversial field, it would not be necessary to specify the concept. In that case, the fact

that one profession invaded the professional field of another profession would directly mean that the monopoly on the field broke. However, in the Korean case, two professions' essential and related fields were focused, and the players had to function as both attackers and defenders at the same time. Therefore, Abbott's concept needed to be further specified into two dimensions, professional field and degree of possession, in order to analyse the Korean case.

6.6.2 Environmental Factors of the Conflict

6.6.2.1 Organisational Factors

Abbott (1988) hardly referred to managerial issues within individual professions. However, organisational features of professions, such as leadership and mobilisation of members and voluntary actions, were important forces during the conflict over the separation system to affect success in achieving their jurisdictional claims. Through the conflict, the two professions developed their own organisational capacity. While interviewing the key leaders of the medical professions, I recognised the following specific points with regard to the organisational factor, which was not specified by Abbott.

Firstly, during the conflict, the professions experienced a shift of generations in their leading group. As pharmacy did in the former conflict with oriental medicine, western medicine experienced a disturbance within the executive of their association through the conflict with pharmacy. The younger reformists took power and led policy, which caused their internal reform. The young power actively, and effectively at the beginning, mobilised members against other medical professions and the government.

Secondly, the conflict caused modernisation of the individual associations. In handling the conflict, the leading group of every profession developed its association by staffing and reorganising. The Korean Medical Association executives divided their work into specific areas and hired staff according to the changed organisation. Full-time directors increased from only one to six and the support force, such as the academic department and the newspaper department, became more active through the conflict.

Thirdly, with the conflict, medical professions' autonomy and mobility increased. In the beginning, diverse and voluntary groups in western medicine, such as the Meeting for Saving Small Clinics or the Democratic Physician Society, came into being. They actively joined the process of decision-making in their association and worked through the internet and in medical practice. While western physicians had not been interested in a collective action before, they then realised its importance and necessity.

Fourthly, when facing its second conflict, pharmacy came with a stronger and more stable organisational system. This brought the head office of the Korean

Pharmaceutical Association skilful leadership and intelligent strategy when facing western medicine and persuading other groups. It implied that the profession, which had already undergone internal reform and organisational improvement in its first conflict, tended to have an advantage in its second conflict.

6.6.2.2 Internal Stratification and Dominant Power in Health Care

According to Abbott, internal stratification and the existence of dominant power in a professional system are important factors which change professional jurisdiction. In the medical system in Korea, there had been an internal differentiation between western medicine and pharmacy. From the perspective of professional knowledge and influence in health care, there had been no doubt that western medicine had *dominant power*.

Nevertheless, when the conflict broke out between the two professions, western medicine did not win, which challenges Abbott's (1988) opinion about dominant power. This showed that the influence of pharmacy had grown enough to contend with western medicine and become a rival. From this perspective, internal differentiation and the existence of dominant power in a professional system were not linked to the professional conflict between western medicine and pharmacy and its result. From the perspective of pharmacy, the separation system would bring the equal division of labour between western medicine and pharmacy and deny the existing unequal *or* hierarchical stratification between them. Pharmacists' strength in the public field including the legal system and public opinion appeared to influence the existing internal stratification between the two professions and threaten the dominant power of western medicine in health care.

Another peculiar point with regard to internal stratification was the hierarchy that formed between specialists and trainee doctors within western medicine. Now less than 10% of western physicians who have an independent job are general practitioners and they are older. Almost all general practitioners in the young generations choose to work under the strict control of specialists and undertake heavy work and trainee courses in order to become specialists. This internal stratification in western medicine was a strong force during the conflict. Young trainee doctors rose up against the separation system and led the *war* against pharmacy and the government.

For young doctors, the separation system appeared to be a great threat to their future professional and economic stability. While trainee doctors' poor position hardly improved within western medicine, stratification became the driving force in the external conflict with pharmacy. The strict hierarchy between seniors and juniors and the strong solidarity between members did not allow any resistance within a profession. Therefore,

instead of choosing an internal conflict between specialists and trainee doctors from the increase in their members, western physicians chose an external conflict with other professions.

Abbott referred to professional competition or conflict in universities over financial support and kinds of courses as cultural factors (Abbott, 1988: 208) in jurisdictional conflict. However, the training course issue was more controversial in the Korean case than his comment suggests. The scheme of pharmacy to lengthen the period of their training course showed how reinforcing the existing training course was a serious cause of conflict between medical professions. As shown in Abbott's quote (1988: 195), pharmacy in Korea also realised that "higher education ... [is] the most important element of professionalism (Ben-David, 1963:256)." In the Korean case, extending the training period for pharmacy had a practical sense that they could develop their professional skill and knowledge, as well as a symbolic sense that they would obtain a social position almost as high as western medicine. Western physicians did not defy the hope of pharmacy from the latter symbolic perspective, but they expressed a strong opposition to the practical purpose of pharmacy. Pharmacists expected to have clinical experience with the longer training course, which western physicians and oriental doctors considered threatening to their sole jurisdiction of practising medicine. They believed that pharmacists would demand the same right to practise medicine with patients that western physicians already had.

In Korea, the issue of the training system emerged after the completion of the external professionalisation for individual medical professions, such as examinations, licensing or registration, disciplinary committees, accreditation and ethical codes (Abbott, 1988:193). In addition, it was when all settings in health care settled down. Only when the conflict with pharmacy was over, did western physicians and oriental doctors realise the pharmacists' influence and intention. Therefore, western medicine and oriental medicine were sensitive to their opponent's scheme and then strongly opposed the new training system for pharmacists.

6.6.2.3 Social and Political Factors

Although Abbott does not give much attention to a social movement as a factor influencing jurisdictional change, it was an important force in the conflict over the separation system. Because social movements were closely linked to political situations in Korea, I now refer to social and political factors. There were two different periods, which influenced the jurisdictional conflict. The first was linked to social and political movements in the 1980s, which had formed the personal, social and political inclination

of the leaders in western medicine and pharmacy. The second was linked to the social and political movement in 1999 to 2002, when the conflict broke out.

The medical conflicts made young reformists in every profession emerge as leaders in their individual associations. They were members of *the so-called 386 Generation*, who had shared particular cultural experiences during their university days in the 1980s. Different from former and later generations, the 386 members were accustomed to organising and mobilising organisational resources. In addition, they were the first generation to experience a rapid increase in the active use of a personal computer for communicating. This influenced their attitude when working in society and communicating with others. During the conflict, *the 386 Generation* took important positions in their own associations and led actions against other medical professions. Although they were on opposite sides in the conflict, their origin and attitude were the same, which made the conflict more organised, strategic and active.

The social and political movements around the conflict were also influential. The conflict started in the middle of the period of the first liberal government party in Korean political history. Because the government party emphasised equity in every field in society, the voice of the weak became bigger than ever before, and the conflict between western medicine and pharmacy reflects this social atmosphere. As the weaker player, pharmacy received more support from public opinion, civil pressure groups and the government. From a different perspective, western physicians' resistance to the separation system was the first and only visible counterattack by conservatives against the liberal social and political atmosphere. The ideological collision between political conservatives and political liberal in the medical conflict became more specific and severe as the Korean Presidential Election approached.

Under these social and political circumstances, civil pressure groups on the liberal side were deeply involved in the conflict. The appearance, development and activities of civic groups were one of the most outstanding features in Korean society during the 1990s. Although there was a criticism that they were close to the then liberal government, they became officially concerned in the conflict as a neutral arbitrator between professions. Though they changed their position into an attacker of western medicine, they played an important role in leading public opinion.

Another peculiar social situation was that until this conflict, Korean society had rarely experienced active controversies or criticism of western medicine by the press and public opinion. The government also realised this phenomenon and the importance of public opinion, creating a background of doubt that the government may have made a spin against western physicians with civic groups and the press. Although western

medicine criticised the situation as populism or journalism, the social atmosphere was not easy to restore. The liberal and open atmosphere at that time was not on the side of western medicine. As western medicine increased its resistance, the pressure against western physicians became stronger.

With regard to the social atmosphere, professional morality emerged as an important issue. At that time, the whole country seethed over the issue of the *margin* in health care. Though there was an explanation of why the *margin* had to exist under the national health insurance structure, people did not want to listen to the complicated reason or history. The existence of the *margin* itself was fatal to the perceived morality of western medicine. The strike of western physicians was another moral controversy, because the public did not understand why doctors would strike for any reason that abandoned patients. At that time, there were social movements to urge *noblesse oblige* particularly from young generations⁶¹, which had been ignored in modern Korean history. The demand for morality in the elite of Korean society was highlighted.

At the end of the conflict, the issue of self-purification emerged in western medicine and pharmacy. According to interviewees, morality in the medical professions would be a more important factor in future health care.

In western countries, the moral issue had appeared in the early stage when a profession had started to form their organisation. In Korea, the code of ethics for medical professions had been already formed when national associations were established. However, there had been few chances to “truly” discuss the morality of professions. Only with the conflict over the separation system did the issue emerge, implying that professionalisation in Korean health care had so far been focused on an external shape, a legal form. From a different perspective, this also could imply that conflict made true professionalisation in Korean health care complete.

6.6.3 Who Regulated the Conflict?

6.6.3.1 Claiming Sole Jurisdiction in Different Areas

Abbott suggested that jurisdictional claims could be made in the following three arenas: public opinion, the legal system and the workplace. The conflict between western

⁶¹ At the Presidential Election of Korea in December 2002, the strongest candidate from the conservative party did not ultimately overcome the scandal that two of his sons did not join the army, although the military service in Korea is compulsory for every man. Even at that time, old generations understood that it was neither surprising nor blameable. They thought it was natural and unavoidable that people in high class enjoyed their own privilege without any consistent responsibility.

medicine and pharmacy developed into a so-called war. Those three arenas were perceived as battlefields.

A. Public Opinion

Western medicine and pharmacy collided with each other to obtain public support. Using the interviewees' expressions, it was an advertising war that involved spending a huge amount of money. However, there was a large gap between the two professions in the frequency and strength of ads. While western medicine poured its efforts and money into ads, pharmacy attempted to control what they did. At the latter stage, the government used ads against the arguments of western medicine. In spite of western medicine's efforts in advertising, public opinion was not on the side of western medicine. The press revealed the western physicians' *margins* from pharmaceutical companies, and this made public opinion critical of western physicians.

In addition, people blamed western physicians for their strikes. Western medicine was the last medical profession to introduce and use collective actions. As other professions had done before, western physicians started with an original, radical type of collective action. However, it did not appeal to public opinion, because people believed that western physicians were the richest persons with the highest social position, and that they did not need to take such an action. Pharmacists took full advantage of their former experience of collective action and did not use it at that time. To attract public support, pharmacists restrained themselves from taking collective actions and kept their image weak. During the physicians' strike, they even volunteered to see patients of striking western physicians.

In this case, Abbott's argument that the arena of public opinion is a pathway to legal arena is right to a certain degree. As western medicine lost public opinion, the players in the political field appeared to evade the physicians' demands or even support. The conservative party asked western medicine to abstain from representing doctors' support to them. This revealed that public opinion influenced the political and legal fields.

B. Legal Arena

As in the former conflict between oriental medicine and pharmacy, the legal system emerged as the first battlefield in the conflict over the separation system. The separation scheme had been legislated in 1994, as a term of the settlement of the conflict between oriental medicine and pharmacy over preparing oriental medicines. That the legal arena was the first conflictual field was hardly found in Abbott's theory (1988). Conflict in the workplace or in public opinion came first.

However, in Korea, the two largest conflicts actually began in the legal arena. This was a peculiar point, because it meant that a policy triggered a conflict, with its settlement in the legal system being another conflict in Korean health care. As all sets had taken their own positions, a sudden change or decision in the legal field, which required mandatory actions, provoked professionals' resistance and threw the situation into confusion. This also implied that because the decision-making processes in the administrative, legal and political fields were not open, professionals did not have an opportunity to discuss or understand a controversial issue in advance. From a different perspective, the government's late attempt to fix a policy, which had been ignored until then only to remain in the law unenforced, caused a conflict.

After their first conflict with oriental medicine, pharmacy had prepared the separation system. However, western medicine did not believe that the government would *really* enforce it according to the law. These different attitudes of the professions to the separation scheme reveal that pharmacy and the government took the initiative and then led western medicine in the formation of the separation system in the legal and administrative fields. Western medicine had to be pulled into that field, only resisting the scheme.

As in the former conflict, this one also included lobbying processes and political actions by professions to win the legal system. As with oriental medicine in the former case, pharmacy already experienced in persuading the political field used their refined step-by-step and bottom-up strategies to persuade the government and the political field. In addition, they also had their colleagues *within* the public system, which was the strongest point for pharmacy. In contrast, western medicine was unskilled and inexperienced in contacting the government. They only believed in their potential influence on the political system. With all points and situations above, western medicine had to lose the legal field.

C. Workplace

Compared with the other two arenas, the workplace was the least favourable field for pharmacy, primarily because of the original health care roles and relationships they had shared with western physicians. As a conflictual field, the workplace can be discussed with the following two parts: before the separation system and after the separation system. Before the separation system, the two professions seldom faced each other in the workplace. Medical clinics and pharmacies were considered separate and independent facilities. Only western physicians and pharmacists in medical hospitals related with each other and that relationship was hierarchical. Although there were pharmacists' complaints

to western physicians in hospitals, they were rarely acknowledged. As the issue of the separation system emerged, the two professions' mutual criticisms became stronger. However, in the workplace, they still had few chances to face each other.

After the separation system, most pharmacists have needed western physicians' cooperation. To receive more prescriptions without any difficulty, pharmacists have wanted a good relationship with doctors in nearby medical clinics. Though the Medical Service Act prohibited an improper agreement or collusion between medical facilities and pharmacies, interviewees implied that there were unofficial and indirect ways in which western physicians influenced their patients' choice of a pharmacy. This situation caused pharmacists to feel subordinate. Nevertheless, the relationship between the two professions appeared to be changing into a "good" one.

As shown above, in the arenas of public opinion and the legal system, pharmacy earned good points. In the workplace, individual pharmacists assumed themselves a lower position in order to establish good relationships with western physicians. However, even in the workplace, western physicians were not stable, because pharmacy was taking specific measures, such as prescribing substitution medicines, which were favourable to them, into the legal arena. This meant that their influence in the legal arena, which was affected by public opinion, was actually more important than their professional position and relationships in the workplace.

6.6.3.2 Role of the Government

There has been criticism against the government's role during the conflict, because it failed to manage the disorder and its reactions and policies were not consistent. Nevertheless, the government was actively involved from the beginning to the end as the starter, arbitrator and settler of the conflict over the separation system. The later part of the conflict was one between western medicine and the government, not western medicine and pharmacy, because the separation scheme was, at least officially, led by the government.

In the Korean case, the government had created the new scheme, caused the conflict, and then arbitrated and settled it. In order to settle the conflict, the government attempted diverse political and economic measures: the Office of the (Korean) President also attempted to control the situation and there had been five occasions of increase in medical fees in NHI. As in other late developing countries, the Korean government had played an active role in every field and every social system. Therefore, the government's active role in this conflict was not strange either to the government or to the professions.

“We only trusted the government and what it did (*WesternPhysician13*)”, commented one western physician.

In the field of administration at the bureaucratic level, pharmacy had an advantage. As shown in the comments of interviewees, government officials from pharmacy had prepared and specified the separation system. However, without a political decision, the administrative system alone could not have enforced the new scheme. In the political field at that time, the liberal party took the power and attempted to reform health care. In addition, public opinion which was mainly led by civic pressure groups and the press, strongly demanded reform in health care, particularly in western medicine. Therefore, the government was able to enforce the new scheme.

6.6.4 Conclusion

The conflict between western medicine and pharmacy was the biggest professional conflict in Korea. Its eruption was anticipated when the first conflict was settled by making the separation system one of the arbitration conditions.

The conflict revealed not only jurisdictional, but also economic and political, characteristics. The motives of monetary benefits and political influence were particularly explicit when compared with Abbott’s cases and this resulted in a serious professional identity crisis and professionals’ frustration. Medical professionals became sensitive to how a jurisdictional change could cause both a change of income and professional positions. Political movements and atmosphere were another important force which influenced the conflict. It is difficult to find a better example to explain the importance of political factors than in Korea, because neither the UK nor the US has experienced this kind of political upheaval over such a short period.

Various factors that were different from Abbott’s work influenced the conflict and the jurisdictional change. Firstly, organisational development with the jurisdictional conflict was an outstanding feature, as in the first case. The conflict helped individual medical professions develop and modernise their association. When facing their second conflict, pharmacy had better organised management and more skilful strategies. Secondly, the dominant power of western medicine in professional knowledge and skill could not overcome the strong point of pharmacy in its political strategy. Thirdly, internal stratification and competition in the professions burst into external conflict with other professions, rather than into internal conflict. Fourth, social movements, mainly political and social democratisation, were an important factor in the Korean case. Fifth, the morality of a profession only emerged as a new hot issue in health care, implying that

professional conflict prompted the completion of professionalisation in a substantial, not just formal, way.

The liberal government's commitment to reform health care drove enforcement of the separation system and western medicine could not avoid being the main target of reform. The government failed to keep their initiative in controlling the situation and there were fluctuations in their strategy during the conflict. Nevertheless, the separation system was implemented in almost the same form that the government had devised. Different from the first case, in which the government accepted demands from both profession in conflict, in the second case, the government was consistent in its attitude toward reforming western medicine in order to reform health care.

Civic groups played more important roles than in the first case. Their reformist attitude was consistent with the purpose of the liberal government, and in fact, a few key members of civic groups led in devising the separation scheme. Therefore, their role changed from that of peacemaker at the first stage to that of an attacker of western medicine, which opposed the separation system. Civic groups strongly influenced public opinion to enforce the separation system. However, their "over-political role" was reflected upon and re-evaluated even by themselves, causing them to reconsider their action and strategy.

With this conflict, western medicine's existing influence as the mainstream of the medical professional system was damaged. In spite of having the strongest professional position in health care, western medicine did not overcome the political environment that favoured reform and the social circumstances that leaned toward liberalism. From the conflict, western physicians not only lost their incomes, but their public image as a noble professional became that of a philistine after monetary interests. This experience gave western medicine an important opportunity to reorganise their association and develop their managerial strategy and political capacity. In the mean time, the conflict gave pharmacy an opportunity to strengthen its position in the medical professional system. Even though their professional position has been the weakest among the three professions, pharmacy has developed its own social and political networks to overcome its professional identity crisis. In addition, with the support of those social and political circumstances aimed at reforming health care and western medicine, pharmacy was able to reinforce its influence through its second conflict.

CHAPTER 7. CONFLICT BETWEEN WESTERN MEDICINE AND ORIENTAL MEDICINE

In this chapter, the third case of professional conflict in Korean health care is analysed. In the former two cases, three main medical professions were involved. Here, the conflict between western medicine and oriental medicine, two professions which individually had faced pharmacy before but had not yet faced each other, is discussed. The present conflictual situation between them, which is now submerged but could potentially become the biggest strife in Korean health care, is examined and analysed.

By analysing the conflict between western medicine and oriental medicine, we can understand the relationship among the three main medical professions and then the medical professional system in a more comprehensive way.

This chapter shows two controversial issues between the two professions. One centres around a specific and practical jurisdiction, that is, the medical treatment of *IMS & Needle TENS*. This relates to the matter of whether or not a profession's practice enters the National Health Insurance. The other is a fundamental issue about unification of the two professions. While oriental medicine focuses on the former issue, western medicine attempts to attract people's attention to the latter. Their different focuses suggest that the two professions have different purposes and attitudes from each other. Analysing the conflictual situations from a professional perspective and from that of economic benefits presents the differences as well as the individual positions and basic relationships in the medical professional system.

How the professions prepared strategies for their second conflict and how they responded to situations in ways that were different from their responses during the first conflict are analysed. At the first stage of the conflict, how the government controlled the situations is also analysed.

7.1 Background

During the fieldwork, another potentially hot issue in the medical system emerged as a conflict between western medicine and oriental medicine. The most controversial issue at that time was the medical treatment of *IMS (Intra-Muscular Stimulation) & Needle TENS (Transcutaneous Electrical Nerve Stimulation)*. Others were the appointment of an oriental doctor as the additional doctor responsible for the President of Korea, the establishment of national oriental medical colleges and the establishment of the Oriental Medical Food and Drug Association. All the issues were developing into one topic, which was unification of western medicine and oriental medicine.

In Korea, there are two kinds of medical licences. One is the (western) Medical Licence and the other is the Oriental Medical Licence. The best students in high school apply for medical and oriental medical universities. Western medicine has kept its position as the main stream of the medical system. As the number of western physicians has rapidly increased in the last two decades, oriental medicine has newly emerged as a favourite profession among the best high school students and among other people.

So far, there have been two occasions of large-scale conflict among medical professions in Korea: one between oriental medicine and pharmacy and the other between western medicine and pharmacy. The new emerging conflict occurred between the most important suppliers of medical services in health care, who had not yet faced each other. Western physicians and oriental doctors were expecting the new conflict between the two medicines to be by far the most serious and substantial.

In fact, among suppliers of medical services, doctors and oriental doctors are surely the most important. So far, there has been no fight between them. If there happened to be a war between them... it would be an absolutely, really huge one. The fight between doctors and pharmacists that happened before? No. No match for the new war. Anyway, they [western physicians and oriental doctors] are all doctors, in the same field. We'll never know what to expect [if a war between them breaks out] (*WesternPhysician03*).

With the separated medical licence system, western physicians and oriental doctors had collided with each other in practice. In diagnosing patients, oriental doctors wanted to use medical equipment, such as a stethoscope or a supersonic detector and to control the medical engineers who operated medical equipment, such as the MRI. To face this competition from oriental doctors, the Korean Medical Association asked the Ministry of Health and Welfare to stop and control oriental doctors' invasion (*Medical news 4162, March 2003*). In the meantime, because oriental doctors felt uncomfortable when a few western physicians prescribed oriental medicines, they also asked the government to stop western physicians' use of oriental medicines. These cases show that both medical professions were sensitive to the others' jurisdictional invasion of their own area. The following simple expression pointed out the true feelings of the two individual professions: "Why do you try to do it? It's ours (*OrientalDoctor4*)."

In March 2003, a sensitive issue, which triggered a more conflictual relationship between western medicine and oriental medicine, emerged. 273 clinics and hospitals in western medicine requested the Health Insurance Review Agency to authorise the medical service of the *IMS & Needle TENS* as their new treatment. *IMS & Needle TENS* was designed to release pain by stimulating the patients' muscles or nerves with electro

pins or needles. Western medicine had introduced the treatment from the US, and the Korean Medical Association and the Korean Hospital Association argued that the government should authorise the treatment as an insured medical service by western physicians. The Korean Dental Association supported the argument of the Korean Medical Association and the Korean Hospital Association, because dentists also needed a similar treatment to *IMS & Needle TENS*.

Opposing the western physicians' argument, the Association of Korean Oriental Medicine issued the Statement against Western Physicians' Acupuncturing (AKOM, 2003). In the statement, oriental doctors argued that *IMS & Needle TENS* was not different from acupuncture, the most distinctive remedy in oriental medicine, and it could not be a new treatment in western medicine. Then, they urged the government to return the western physicians' proposal and asked the Korean Medical Association to apologise for their abuse of acupuncture.

In addition to the issue of *IMS & Needle TENS*, other controversies broke out, which increased tension between western medicine and oriental medicine. One was that Dr. Shin HyunDae, an oriental medical professor, was appointed as the additional doctor responsible for the President of Korea. That had been one of the new President's election pledges.

The whole of western medicine is astonished and enraged, because the President of Korea recognised non-scientific oriental medicine as a medical profession equal to scientific western medicine (The Korean Weekly Doctor, 2003).

Another controversy arose over establishing oriental medical colleges in national universities in May 2003. The issue had been a long-cherished objective of oriental medicine and became a symbol that the nation would support the oriental medicine development. The new government specifically announced that an oriental medical college would be established in Seoul National University in 2005. The government also decided to create the Oriental Medical Food and Drug Association, which was separate from the existing Korean Food and Drug Association. With this series of policies for oriental medicine, western medicine changed its attitude toward oriental medicine into a hard line.

7.2 Different Motivations and Perspectives of the Conflict

7.2.1 Conflict from the Professional Perspective

At first, the conflict between western medicine and oriental medicine over *IMS & Needle TENS* was a specific jurisdictional one over a treatment to release pain with a needle or acupuncture. However, beneath the external one, there was a fundamental matter of whether an entire profession could exist or, according to oriental doctors, be extinguished. Here, I will examine and analyse both the specific and the fundamental conflict between the two professions from the professional perspective.

7.2.1.1 Conflict over *IMS & Needle TENS*

Under the present legal system, the division of jurisdictions between western medicine and oriental medicine is not clear. According to the Oriental Medical Service Act, practice and medicines based on oriental medical theory should be oriental medical practice and oriental medicines. There are neither regulations nor notes to specify the provision. The only clue and the key word is oriental medical theory. Therefore, if a new controversial medical item appeared, it should be individually examined and decided. If any practice or medicine is found in oriental medical theory, it belongs to oriental medicine.

The game already started: who will occupy one first? ... To take an advantageous position, the professions concerned accumulate their own evidence and data. Organising an academic society, publishing an academic journal about the controversial item. If a trial or judgement were initiated, those data and evidence would play an important role (*OrientalDoctor3*).

One of the most important professional causes of conflict between western medicine and oriental medicine in Korea is linked to the medical trend in the UK and the US. In those western countries, alternative and complementary medicine, which originated in oriental or traditional medicine, has emerged and gained attention. In recent years, some western physicians in Korea have introduced complementary and alternative western medicine mainly from the US to western medicine in Korea. Therefore, those alternative medical treatments have been considered as an arena of western medicine in Korea, a topic about which western physicians and oriental doctors show totally different opinions. Western physicians argue that the newly introduced medical treatments are theirs, because western physicians imported them from western medicine in western countries and they can be explained by western medicine. However, from the perspective of oriental doctors, complementary and alternative medicine is not new, because its origin is mainly in oriental medicine. Oriental doctors felt upset that some treatments of their

oriental medicine were being imported from western developed countries, as if they were totally new and different.

Western physicians [in Korea] don't try to believe in the efficacy of oriental medicine. ... Even western physicians in the US and the UK know the effect. Nevertheless, ironically, some important treatments in oriental medicine have started to flow in from western countries by western physicians. I think it's really awkward! (*OrientalDoctor4*)

The different opinions from the individual professions above apply to the recent case of IMS & Needle TENS in Korea. Western medicine argued that the government should authorise IMS & Needle TENS for doctors, because they introduced the treatment and its process and result were explained by anatomy and nerve psychophysiology in western medicine. Western physicians argued that the originator of the Needle TENS was Dr. Gunn in the University of Washington Medical School, who studied 'modern western medicine'. Western physicians said that Dr. Gunn's academic career proved that the origin of IMS was not oriental medicine (Ju, 2003). However, Dr. Kim in oriental medicine refuted this argument of western physicians in their first open dispute on the radio. According to Dr. Kim, Dr. Gunn and his family were Chinese emigrants, and his study was rooted in oriental medicine and influenced by his ancestors.

Another external refutation of oriental medicine to western physicians' arguments was the statement by the Association of Korean Oriental Medicine prohibiting western physicians' acupuncture. In the statement, oriental doctors contended that *IMS & Needle TENS* was the same with *ChimJaSul* & *ChimJeunGiJaKeukSul* in oriental medicine, which had been used to release pain as a part of acupuncture. They maintained that they also included anatomy in the oriental medicine curriculum and that *ChimJaSul* & *ChimJeunGiJaKeukSul* were explained by it.

Oriental doctors realised that the damage from losing the conflict over IMS & Needle TENS would be even bigger than that of the former conflict with pharmacists, because acupuncture was an essential part of oriental medicine.

If we commented on only one representative item of oriental medicine, it would be acupuncture. Even after hundreds of years, there will remain only two kinds of practice in oriental medicine [that is, acupuncture and prescribing oriental medicines], while western medicine will have many kinds of practice (Dr. W. in the Emergency Meeting of oriental medicine).

7.2.1.2 Conflict over Unification of Western Medicine and Oriental Medicine

For western medicine, however, the issue over *IMS & Needle TENS* was only a starting point. Fundamentally, the Korean Medical Association wanted to discuss unification of western medicine and oriental medicine. Even in the debate over *IMS & Needle TENS* on the radio, the representative of western medicine emphasised the necessity of unification (Ju, 2003). Unification was the ultimate purpose of the Korean Medical Association. From this point, the conflict changed from being one over a specific jurisdiction to one over the existence of an entire profession.

In explaining the main external basis of the western physicians' argument for unification, the key leaders in western medicine interviewed emphasised that over 70% of curricula in oriental medical colleges was the same as that in (western) medical colleges. Therefore, according to western physicians, both medicines could be and should be united with each other.

So, basically to say, there will not be a big problem in unifying them [oriental medicine] and us [western medicine] ... from the academic perspective and then practical medical perspective (*WesternPhysician03*).

A leader in western medicine also argued that unification was needed in order to improve the poor management of oriental medicines.

With regard to the process of producing herbal medicines and other raw materials of oriental medicine, it was not well understood who would produce them and how that would happen. This was different from pharmaceutical companies, where facilities and the production process were under the control of the government. The circulation of herbal medicines was also not clear. If the government is concerned about public health, they should control those problems by combining them into one medical system. (*WesternPhysician03*)

However, the above cause appeared to be a mild and political one. The interviewee was a key member of the Korean Medical Association in the heyday of the conflict with pharmacy over the separation system. When I interviewed him, KMA executives were about to change. While he was straightforward in commenting on the conflict over the separation system that he had experienced and led, he appeared to be cautious when talking about a new issue that would be beyond his control. Instead, the new president of the KMA more strongly argued for unification and criticised oriental medicine.

Unification.. it should be done. Oriental medicine is actually Chinese medicine, not Korean medicine. They argue that something Chinese is Korean (*WesternPhysician09*).

The main criticisms against oriental medicine and the main reason for unification, which came from the new leaders of the KMA and other western physicians in the lower ranks, centred around “the non-scientific and non-professional nature” of oriental medicine. For western physicians, the key was science, which is the strongest point in western medicine from the perspective of professional knowledge and technology, especially when compared with oriental medicine. They insisted that medicine should be the only one for public health and that it must be scientifically explained. According to them, only evidence-based medicine was acceptable. There were visible movements in western medicine to discover non-scientific and superstitious medical treatments. For example, half of the articles in the website of Health & Science Korea (<http://www.hs.or.kr>) pointed out that oriental medical knowledge and practice cannot be explained by scientific bases or analyses. They also gave examples of oriental medicine harming patients. Most western physicians did not believe in the efficacy of oriental medicine.

The interviewed western physicians’ opinions of oriental medicine and unification can be divided into the following three categories. The first group showed rejection of oriental medicine. Most western physicians interviewed did not want to recognise oriental medicine as a medical profession, because they considered it full of superstition that is not helpful, but often harmful, to public health. This explains why western physicians criticised the appointment of an oriental medical professor as another doctor responsible for the President of Korea and why western physicians opposed establishing national oriental medical colleges with this “non-scientific and non-professional nature”. The western physicians in this group argued that oriental medicine was exaggerated and overestimated by nationalism and traditional values.

I don’t think it [oriental medicine] is a kind of medicine.
(*WesternPhysician13*)

Their sayings are all non-scientific and not evidential. Then, they are superstitious... If a medical accident occurred, they would have no responsibility because it is not evidential. What’s that? ... Holistic? Ye, they can treat all kinds of disease at the same time. ... Why didn’t they win the Nobel Prize? (*WesternPhysician05*)

When an oriental medical professor was appointed as the additional doctor responsible for the President of Korea, medical professors argued that the existing western physician responsible for the President, a medical professor in Seoul National University, should resign his post. They would not admit the fact that a western medical professor in Seoul National University was treated on a par with an oriental medical professor (The Korean Weekly Doctor, 2003). Some western physicians regarded it as something that hurt their pride.

The second group in western medicine were mainly indifferent to oriental medicine and only half-heartedly accepted the effectiveness of oriental medicine. The expression that “oriental medicine... may have some effects in some field, or not” represents their position. However, they were not pleased with the fact that oriental doctors attempted to use western medical equipment and treatment.

I judged traditional medicine highly based on their experience. But.. recently they have tried to use western medical equipment and our treatment. I believe that's wrong. (*WesternPhysician08*)

For the last case, there was one exceptional western physician who *respected* both oriental medicine and alternative medicine. Further, he became interested in alternative medical practices and actively wanted to introduce them to his clinic. There was a particular background for his attitude. His speciality was diagnostic radiology, in which the number of members in western medicine was small. His speciality found it difficult to attract patients independently and his income mainly depended on the “unreasonably low” fees in the NHI. In addition, he continuously invested in cutting-edge and expensive medical equipment. Then, he expected to expand the scope of his practice to other arenas, such as *IMS & Needle TENS* or Taping Therapy for pain release or obesity therapy. He believed that those areas appealed to patients, without his having to make additional investments in medical equipment. His opinion on unification was not clear. However, if unification were to make it more convenient for him to use those alternative or oriental practices, he would agree on unification. Even if he respected those practices, he still felt frustrated about having to go through a side path, regardless of his original speciality.

As a professional, my pride gets hurt. I would not have chosen this speciality to do such things... (*WesternPhysician06*)

As shown above, in my fieldwork, few interviewees positively admitted or supported oriental medicine. They doubted its efficacy and were reluctant to admit it as

an equal medical profession. This professional attitude of western physicians made them argue for unification. Even if some of them recognised oriental medicine as an independent “field”, not profession, they wanted oriental doctors to remain in their own arena and not employ a western medical approach.

In contrast, the leading group in oriental medicine did not even want to refer to unification. Their only opinion was that the issue of unification should be examined only after a deep and careful study for the people, not for suppliers of medical services. The leaders only wanted to concentrate on the issue of *IMS & Needle TENS*. In practice, however, the issue of unification provoked attention and serious controversy among oriental doctors. Most oriental doctors interviewed opposed unification. On the bulletin board of the website of the Association of Korean Oriental Medicine, major messages were also against unification. They believed that unification suggested by western medicine was “to absorb and extinguish oriental medicine (*OrientalDoctor4*)”, although oriental medicine had its own particular professional knowledge system and then its own importance as a medical profession. However, not all completely opposed unification. One interviewee and some messages on the bulletin board suggested a different opinion from the majority one.

First of all, the main basis for opposing unification in oriental medicine was their professional and practical “superiority”. Against western physicians’ criticism that oriental medicine was non-scientific, an oriental doctor argued:

Western physicians, who hold a cultural hegemony in this age, are only forcing oriental medicine to apply their own measure. In western medicine, the concept of science is only applied to something visible. It’s wrong, because science means only something that had its own foundation, logic and consistency, regardless of visibility. ... Even excellent scientists who major in cutting-edge technology would acknowledge the limitation [of science]. Even in the US, one of the most scientifically developed countries, alternative medicine is emerging. It is odd that only western physicians [in Korea] argue that they can explain everything and only they are right. It’s their illusion (*OrientalDoctor1*).

He complained that a considerable part of western medicine actually harmed patients with their overuse of drugs, injections and operations.

My mother-in-law had an operation in one of the best hospitals. After the operation, she did not recover consciousness well. Her physical condition was not suitable for being under anaesthesia or other western medical treatments, but they [western doctors responsible for her] had not caught it. I brought her from the hospital to my [oriental] clinic to give a therapy for her own physical condition. Now she is OK (*OrientalDoctor2*).

Another oriental doctor (*OrientalDoctor1*) argued that oriental medicine was already scientised enough, because 60-70% of their curriculum was the same as that of western medicine. From this perspective, oriental medical education was already modernised and did not need to be scientised any more.

Some doctors in the US judge that our oriental medical curriculum is ideal, since it harmonises 'scientific' western medicine and traditional medicine. Western physicians argue that oriental medicine lacks scientisation. However, we have already imported a tremendous scientific and academic curriculum and practice to oriental medicine. (*OrientalDoctor1*)

A different opinion was that oriental medicine would lose its own strength with an indiscreet attempt at scientisation. The following comment shows a practical anxiety of oriental medicine.

Scientisation itself might be desirable and have no reason for objection, based either on international tendency or on objectivity. However, ... who would be the main body responsible for scientising oriental medicine? There is a high possibility that only the forms would be introduced from western medicine, and, in the end, they, the means or the tools, would replace the core. The spirit of oriental medicine which is the most important part in it would be extinguished. That is why I object to scientisation (*OrientalDoctor1*).

In fact, since the mid 1990s, the movement to scientise oriental medicine by developing high-tech equipment and using it has been active. I asked *OrientalDoctor1* how effective the use of high-tech equipment in oriental medicine was. He replied that the general evaluation of it by oriental doctors was still unsatisfactory. According to him, there was a gap between oriental doctors' diagnoses and those by equipment, because there was a fundamental limit in using a western tool and technology to explain traditional concepts (*OrientalDoctor1*).

Most of all, most oriental doctors interviewed had a basic pride in their profession, whether in their knowledge or their practice. Therefore, they believed that they were surely worthy of existing independently of western medicine.

The potentiality of oriental medicine is huge. Coverage of oriental medicine in practice is very wide. Let's see the scope of treatment for acupuncture. We can release cancer patients' nausea with acupuncture without any western medicines. In cancer patients' chemical therapy, nausea is the most difficult thing, and we CAN treat it. (*OrientalDoctor4*)

The reason people trust oriental medicine is that it WORKS for patients in practice. It has effects, really. Plus, in recent years, people have been more interested in pro-environmental or ecological things. Oriental medicine is consistent with that kind of nature and philosophy (*OrientalDoctor1*).

According to both the interviewees and the messages on the bulletin board of the Association of Korean Oriental Medicine, the opinion against unification prevailed in oriental medicine. Most oriental doctors believed that oriental medicine was a philosophy that was more than science, and they did not want the dangerous situation of oriental medicine possibly disappearing.

Why do I oppose unification? ... If two different medicines with completely different paradigms were 'unified' in such a hurried and convenient way, oriental medicine would be extinguished. It doesn't mean enhancing specialisation in oriental medicine, but pushing it into an unfit paradigm by force (*OrientalDoctor6*).

With regard to herbal medicines, we faced the attack from pharmacists. With regard to diagnosing and treatments, there is assault from western physicians in terms of unification. We are in danger of breaking into pieces in the air (*OrientalDoctor4*).

Now pharmacists are invading our field by preparing herbal medicines, and western physicians are entering the field of acupuncture before our eyes. Then, who on earth does argue for unification? Is he a true oriental doctor? Do you [who argue for unification] mean that we should commit suicide in front of our enemy? (*OrientalDoctor7*).

There is no country such as ours, where the brightest high school students apply to oriental medical universities and become oriental doctors. Not even in China. Therefore, we will and should survive (*OrientalDoctor2*).

However, there were oriental doctors, who had another opinion. One interviewee, *OrientalDoctor3*, confessed that oriental medicine requires scientisation, particularly before opening the health care market to foreign countries in 2006. To survive in the future, according to him, the most important thing for oriental medicine is scientisation. He added that the scientisation of oriental medicine would not be achieved without the help and the cooperation of western medicine (*OrientalDoctor3*). Although he did not openly argue for unification, he was the only interviewee, who was affirmative to western scientisation of oriental medicine.

The health care market will start to open soon. If our oriental medicine is introduced to other countries...? Western countries will require a strict

international standard or WTO standard in practising medicine. If oriental medicine does not meet those requirements, it will be weeded out. Only within our country can oriental medicine survive. ...But most oriental doctors don't recognise this serious situation. 'I can persuade them [patients in foreign countries], give them a belief and then cure their illness'. They are sometimes likely to be missionaries of a religion of oriental medicine. "You should admit this [oriental medicine or my practice] with a belief." Really like something religious.... (*OrientalDoctor3*)

He understood the position of oriental medicine and what oriental medicine was worried about with unification.

If oriental medicine and western medicine unify, unification cannot be equal from the viewpoint of either the number of members or other capacities, although oriental medicine wants to go equally with western medicine. (*OrientalDoctor3*)

Nevertheless, he said that oriental doctors should have something more than a short-range view and consider the changing situation serious.

Now, oriental medicine receives great pressure from alternative medicine, pharmacy and other medical quasi-professions. It is time for oriental medicine to change its paradigm, because in modern society, oriental medicine cannot insist on its monopolistic jurisdiction and methods (*OrientalDoctor3*).

On the bulletin board of the Association of Korean Oriental Medicine, some pragmatists insisted on the inevitability of unification for the future of oriental medicine. According to them, some oriental doctors already employ western medical techniques and 60 to 70% of the curriculum in oriental medical universities is already consistent with that of (western) medical universities. Under these circumstances, the pragmatists say that unifying the two medicines is inevitable in order to strengthen the competitiveness of oriental medicine in the international health care market.

According to a young leader of the KMA, about 70% of young oriental doctors supported the plan for unification of the two medicines (*WesternPhysician10*). It is hard fully to accept his statistical figure, since there has been no survey about the opinion of unification. However, "a considerable number" of young oriental doctors are becoming interested in unification. First of all, according to an internal document of the government and oriental medicine, a survey conducted in 1999 revealed that 57% of oriental doctors wanted to learn western medicine, while 39% of western physicians wanted to learn oriental medicine (Ministry of Health and Welfare and the Korean Institute for Health

Care Industry Promotion, 2002). The purpose of the survey was to encourage co-practice between western medicine and oriental medicine. In addition, the survey occurred before the conflict over unification emerged. Therefore, those figures do not exactly reflect the proportion supporting unification. Nevertheless, the fact that a larger proportion of oriental doctors intended to learn from western medicine than western physicians wanted to learn from oriental medicine may imply that oriental doctors are more active in *adapting* themselves to western medicine and would be more positive to unification than western physicians.

Secondly, the key leaders of oriental medicine were concerned about young oriental doctors, who suffered from an identity crisis and attempted to change their practice into a more western style to attract patients. This could be another reason why a considerable number of young oriental doctors may be interested in unification.

Nowadays, oriental medical clinics are changing. Along with young oriental doctors... I'm seriously concerned about them. They are individually introducing western medicine and changing methods of diagnosis and treatment... For some clinics, I ask myself,.. is this a true oriental medical clinic? This might be a strategy to survive, but... the identity of oriental medicine seems to disappear (*OrientalDoctor1*).

Two different opinions on scientisation and unification in oriental medicine show the dilemma facing this profession. Oriental doctors believed that their professional knowledge was superior to that of scientific western medicine but they failed to persuade western physicians to believe in their excellence. They were also concerned about being absorbed into western medicine through unification. In addition, although the government and, at least externally, the Association of Korean Oriental Medicine declared that scientisation of oriental medicine was important for the development of oriental medicine, oriental doctors did not like the western paradigm of scientisation much (*OrientalDoctor1*). Nevertheless, all oriental doctors welcomed the plan of the government for establishing national oriental medical colleges. They believed that national oriental medical colleges would develop oriental medicine in their own way, without being forced by western-styled scientisation.

Regardless of western physicians' or oriental doctors' attitude toward unification, there was an official movement among leaders of western and oriental medicine for unification. A key leader of the Korean Medical Association told the story. During the conflict with pharmacists, the Korean Medical Association contacted oriental medicine over the issue of opening the health care market to foreign countries by the WTO Doha

Development Agenda. At that time, the leaders of western medicine and oriental medicine discussed unification.

Last year [in 2002], I had chances to contact leaders in oriental medicine on several occasions regarding the issue of the WTO DDA [about opening the health care market to foreign countries]. We failed to reach a specific agreement on unification, but there was a considerable advance in opinions to unify curricula in [western] medical universities with those in oriental medical universities. Even at that time, we knew that it would be difficult in practice. It was the problem of which one would bell the cat. (*WesternPhysician03*)

As shown above, the issue of *IMS & Needle TENS* shows another typical jurisdictional conflict suggested by Abbott. Western medicine has attempted to expand their jurisdiction into alternative medicine or oriental medicine by requesting that *IMS & Needle TENS* be covered by NHI. However, according to oriental doctors, it is already the existing oriental medical jurisdiction, acupuncture. Because acupuncture is the most essential practice in oriental medicine, oriental doctors are sensitive to western physicians' actions and have actively attempted to face it.

The issue of unification is a more fundamental and serious jurisdictional conflict than the specific issue of *IMS & Needle TENS*. Oriental doctors believe that western physicians attempted to absorb oriental medicine into western medicine through unification. Their anxiety about the disappearance of oriental medicine might not be groundless, according to the interviewees in western medicine. Western medicine insists upon scientific practice and evidence-based western medicine for public health. Unification would mean the largest jurisdictional change in Korean health care, a change in which one medicine would disappear. Although the Association of Korean Oriental Medicine has not officially responded to this issue, western medicine has been strengthening its attack on oriental medicine. It is a collision between different knowledge systems and values: traditional medicine and culture vs. modern scientific medicine.

7.2.2 Conflict over Economic Benefit

During the conflict between western medicine and oriental medicine, there was also an economic issue or motivation. The *IMS & Needle TENS* issue, rather than the conflict over unification, operated more outstandingly as an economic one. For western physicians, particularly in Diagnostic Radiology and Rehabilitation Medicine, the new practice might contribute to their increased income. Although he was exaggerating, the following comment of a leader in oriental medicine showed the western physicians' economic motivation for *IMS & Needle TENS*.

IMS [& Needle TENS] is not a popular practice even in the US. It is only one method of treatment. Western physicians [in Korea] introduced it in a hurry for economic reasons. There is a rumour that western physicians in Rehabilitation Medicine and Anaesthesia & Pain Release Department cannot keep on managing their own facilities without *IMS [& Needle TENS]*. For their income, they did that [hastened to introduce it]. (*OrientalDoctor4*)

Oriental doctors also had an economic motivation to oppose the western physicians' use of *IMS & Needle TENS*. For oriental doctors, it was a more important economic matter than it was for western physicians, because acupuncture, which was said to be similar to *IMS & Needle TENS*, was the essential jurisdiction in oriental medicine, accounting for 95% of the income of oriental medicine paid by the National Health Insurance (*OrientalDoctor4*). In addition, western physicians attempted to use *IMS & Needle TENS* simultaneously with medicines. Western physicians also applied the treatments to enlist the National Health Insurance. If the government had accepted it, according to an oriental doctor (Dr. G. in the Emergency Meeting of oriental medicine), "90% of oriental medical facilities would have had to close". Therefore, *IMS & Needle TENS* was a large threat to oriental doctors and their economic benefits.

With the issue of unification, the existence of an economic motivation for a profession was more controversial than that with *IMS & Needle TENS*. An important external reason why western physicians argued for unification was to curtail health care expenditure, as well as to protect people from non-scientific practices.

Now, a patient goes first to a pharmacy, [if it did not work,] then to a medical clinic, [if it did not work,] then to an oriental clinic or oriental hospital [if it did not work,] and then, in the end, to a medical hospital [Although the sequence was different, other interviewees also commented on this circulating phenomenon. Two oriental doctors added one: and then he comes back to an oriental clinic or oriental hospital in the end (*OrientalDoctor1*; *OrientalDoctor2*)]. What a waste! This is a national waste. (*WesternPhysician03*)

Western physicians expected unification would lessen patients' medical shopping and the deficits of the National Health Insurance.

However, oriental doctors did not doubt that western physicians wanted a new income source by attempting to absorb oriental medicine.

They [western physicians, pharmacists and dentists] want to tear us [oriental medicine] into parts and just take their share, because we have lots of areas, limitless potential areas to develop. In their own field, they

just have to introduce practices from western countries and follow them (Dr. G. in the Emergency Meeting of oriental medicine).

It is hard for them [western physicians] to publish an article in an international journal only with theirs, but with oriental medicine, they would have a competitive superiority in an international field (Dr. H. in the Emergency Meeting of oriental medicine).

My cousin, an orthopaedist in New Jersey, told me on the phone that, getting older, he lived only with acupuncture there. Overseas, western physicians [from Korea] surely find themselves superior only by going side by side with oriental medicine. (Dr. J. in the Emergency Meeting)

In fact, the economic circumstances were against western physicians. In addition to the separation system, the health care market was already filled with three kinds of suppliers of medical services - western physicians, oriental doctors and pharmacists. Under this situation, the government's recent policies in favour of oriental medicine stimulated western medicine to hasten unification.

The government has already admitted that western physicians were overproducing and now it attempts to decrease the regular number of medical students. Nevertheless, the government again attempts to establish oriental medical colleges. That's absolutely inappropriate medical policy (KMA, 2003b).

The increase in oriental doctors and the development of oriental medicine was a threat to western medicine in the health care market. As the loser in the former conflict with pharmacy, western physicians appeared to have a desperate feeling not to retreat any more. With regard to the circumstances surrounding western physicians, their economic motivation behind the argument of unification could not be denied.

As shown above, there was no specific financial issue in this case, such as *margins* in the former conflict over the separation system. However, the situations and the interviewees' comments reveal that the two professions wanted to improve their financial difficulties by changing, or keeping, the existing jurisdictions. Western medicine was looking for a way to improve their financial situations, particularly after the separation system enforced in 2000. Oriental doctors were also concerned about the rapid increase in the number of their members, as were western physicians. Therefore, a financial difficulty among a large number of medical professionals and a means to overcome it would be judged an effective factor in this case.

Western medicine and oriental medicine are the two medical professions in competition with the same professional function to practise medicine. Therefore, the rival's market can be a good source of new income. However, western medicine denied

that their argument for unification originated in economic arguments. On the contrary, oriental medicine argued that the intention of western medicine came only from economic motivation.

7.3 Strategy and Capacity of Western Medicine

7.3.1 Strategy of the Korean Medical Association

At the first stage when the issue of *IMS & Needle TENS* emerged, western medicine was not so adamant in insisting on unification between the two main professions. Western medicine believed that even if unification was not achieved at once, there would be something for them. They believed that, at least, they could prohibit the ‘reckless’ use of medical equipment by oriental doctors and make jurisdictional boundaries clear.

If *IMS & Needle TENS* are not authorised for western physicians, oriental doctors should also give up using medical equipments. (The Korean Weekly Doctors, 2003)

However, as the government continually showed support for oriental medicine with a series of policies, western medicine appeared to become sensitive to the situation. As western physicians expressed their anger and hurt pride, the voice of unification within western medicine became stronger. Western medicine wanted to develop all related issues into the more fundamental and bigger one, that of unification between western medicine and oriental medicine.

I recognised that from the beginning, western medicine had separate, but well related, organisational strategies in facing the new conflict with oriental medicine. The applicants who asked the government to authorise *IMS & Needle TENS* as new medical treatments for them were 273 individual medical clinics and hospitals that mainly belonged to the specialties of Diagnostic Radiology and of Rehabilitation Medicine. Therefore, academic associations supported the 273 medical facilities and the Korean Medical Association spoke for them in the press. At the same time, the Korean Medical Association emphasised its argument on unification of western medicine and oriental medicine, rather than on *IMS & Needle TENS*. During my fieldwork, February to April 2003, the Korean Medical Association attempted to draw people’s attention to the bigger issue of unification by making the best of the issue of *IMS & Needle TENS*.

At that time, western medicine was attempting to avoid radical or protracted conflict with oriental medicine. Unlike in the former conflict with pharmacy, now western medicine appeared to have a composed attitude toward the developing conflict

with oriental medicine. Their initial calm and composure might come from the following reasons.

First, the issues of *IMS & Needle TENS* and unification were not as big for western physicians as losing the right of preparing medicines had been with the separation system. There was nothing particular for western physicians to lose with the new conflict. In the best case, all western physicians could expand their field by achieving unification. In a better case, some western physicians could obtain a new right of specific practice, *IMS & Needle TENS*, along with the economic benefits from them. Even in the worst case, western physicians could argue that oriental doctors should not use medical equipment, just as western physicians cannot use an electro needle or acupuncture. Therefore, the Korean Medical Association did not push the controversial situation.

Another reason that western physicians were not impatient in managing the issue was that since the 1970s, the Korean Medical Association had continually proposed unification of western medicine and oriental medicine by unifying the different licences. In western medicine, the argument for unification was not new.

Most of all, western physicians were confident that western medicine would not be absorbed into oriental medicine, even following unification. It was a completely different situation for oriental medicine. Therefore, at the beginning, western medicine had composure in facing the new conflict, which helped them develop cautious strategies and attitudes toward the next conflictual situation.

However, post-interviews by e-mail, telephone calls and access to recent news since May 2003 have shown that western medicine has started to change its policy line into a stronger one. Although its rational and cool attitude has not quite changed, western medicine has strongly opposed the government's policy *in favour of* oriental medicine. Now western physicians more actively agree with the scheme for unification and support the issue. In June, the Korean Medical Association, medical academic societies and other medical organisations suggested erecting a Pan-national Council for Unification. Western medicine attempted to rally all their organisations and capacities against oriental medicine.

7.3.2 Resources for and against Western Medicine

This conflict between the two most influential medical professions is expected to be a *big bang* in the Korean medical system. Individual professions will mobilise all they have. Here, I examine factors for and against western medicine in the case of an open conflict with oriental medicine. Because this case has not yet developed into an external one like the former, only the existing factors and situations are examined as potential forces.

When it comes to manpower and financial resources, western medicine is predominant over oriental medicine. The number of western physicians, 75,000, is almost six times that of oriental doctors. In addition, western medicine has strong backups, such as medical equipment and supplies companies and pharmaceutical companies (*OrientalDoctor4*). Although it is difficult to estimate financial resources to be mobilised by individual professions in practice, the following comment implies the predominance of western medicine as a financial influence.

The income of the biggest medical hospital is larger than the total income of oriental medicine (*OrientalDoctor4*).

With regard to organisational and political strategy, western medicine learnt much from the experience of the first conflict and loss with pharmacy over the separation system.

The KMA tuned up its organisation and has shown a refined attitude in responding to the government and other groups after their first conflict. (*GovernmentMember4*)

This reinforced managerial ability of western medicine is a strong point in the conflict with oriental medicine.

In professional knowledge and technology, western medicine is also at an advantage over oriental medicine, because of its systematic and cutting-edge approach, which appeals more to patients.

However, in persuading the government, western medicine might still have difficulties. Although government officials started to agree that a health care policy could not succeed without western physicians' cooperation and that the government should now attempt to include and tolerate doctors' arguments and position, government officials in the Ministry of Health and Welfare are still displeased with western physicians' high-handed manners (*GovernmentMember1*). Although the staff of the new President of Korea have realised that a hard policy toward western physicians should be reconsidered (*Journalist1*), the President of Korea, Roh Mu-Hyun, has not hesitated to hide "his distrust (*OrientalDoctor4*)" and "ill feelings towards western physicians (*Journalist1*)". Therefore, the government does not appear to support western medicine with regard to the issue of unification. In addition, after the conflict between oriental medicine and pharmacy in the mid 1990s, the government has supported the development of oriental medicine. It will not weaken its policy less than a decade before its basic policy for oriental medicine had been implemented.

Public opinion against western physicians has not yet changed. Most of all, during the former conflict with pharmacists, western physicians completely lost public support. The scandal of *margins* and their series of strikes were seriously criticised by civic groups, the government and the press. A figure in the press commented as follows:

[If the conflict between western medicine and oriental medicine emerges,] Still there will be an antipathy against western physicians. People still have bad feelings against western physicians because of the medical disturbance with pharmacists. Then, another fight with oriental doctors? In addition, over acupuncture? No, western physicians will not get public support. (*Journalist2*)

Not long after the former conflict, people still have ill feelings toward western physicians. For example, if news emerges on the internet about a mishandled operation or excessive profits in a medical facility, the news bulletin board explodes with criticism and condemnation of all western physicians. It is an outstanding phenomenon that is hardly found in other news items. Under this situation, people will not support western physicians' argument of *IMS & Needle TENS* and unification, however rational and logical the suggestion might be.

In the meantime, western medicine has met a friendly force - pharmacy. Although they had a strong conflict with each other over the separation system, they shared the same voice against oriental medicine and for unification. Pharmacy was also unhappy with the government's policy in favour of oriental medicine (KPA News, 2003). The Korean Pharmaceutical Association issued a statement to the government and the political field urging them to show a firm position for unification. In the statement, pharmacists showed their strong opposition to the government's policies for oriental medicine (KPA, 2003). The conflict over unification will break out between the allied professions of western medicine and pharmacy against oriental medicine.

7.4 Strategy and Capacity of Oriental Medicine

7.4.1 Strategy of the Association of Korean Oriental Medicine

In their conflict with western medicine, oriental doctors attempted to suppress the development of the issue of *IMS & Needle TENS* into that of unification (Kim, H., 2003). They only wanted to protect their monopolistic jurisdiction, acupuncture. The data collected during my fieldwork show how seriously oriental doctors felt a crisis and then how strongly they intended to face western medicine over the issue of *IMS & Needle TENS*. To keep their essential jurisdiction, oriental medicine was "willing to fight with western medicine by any means".

When the issue of *IMS & Needle TENS* emerged, all organisational strategies and efforts in oriental medicine were centralised to stop the government from authorising *IMS & Needle TENS* in the National Health Insurance. Oriental doctors, in particular working in oriental medical clinics, recognised the seriousness of the situation. As soon as the issue emerged, the internet bulletin board for the Association of Korean Oriental Medicine website was filled with messages to encourage “a large-scale war” with western medicine.

In order to prevent western physicians from obtaining authorisation for *IMS & Needle TENS* as their new treatment, oriental doctors hastened to develop academic and theoretical bases. According to the present health care policy, the government can admit a treatment by a medical profession, only if medical theory proves it in reference as evidence. Under this situation, oriental doctors realised that the conflict over *IMS & Needle TENS* must be an academic war.

In addition, while learning from their first conflict, oriental doctors believed that they would obtain more benefits by using rational and composed ways in their second conflict with western medicine.

We lost the last war with pharmacists, either in practice or in justice. Now we are facing a more threatening opponent. At this time, a fight should be only the last alternative. ... We should not hasten to make war. ... We need academic discussions, open hearings or forums. Then, we will be able to overwhelm western physicians and obtain more support from the public (*OrientalDoctor8*).

The Emergency Meeting⁶² of oriental medicine, which I attended as the only outside observer, also showed how oriental medicine set up its organisational frame and strategy to face western medicine.

We had barely managed to win the conflict with pharmacists primarily through publicity activities and by gaining public opinion. At this time, the situation is different. We desperately need an academic basis to win the war. (Dr. H. in the Emergency Meeting of oriental medicine)

Without academic resources to refute the western physicians' argument, all other activities, either policy or public relations, will be meaningless (Dr. J. in the Emergency Meeting of oriental medicine).

⁶² It was held on the 3rd April 2003. The ten persons present were leaders of the Association of Korean Oriental Medicine, the Korean Acupuncture and Moxibustion Association and oriental medical colleges.

In the meeting, the president of an academic association in oriental medicine, was to take charge of the emerging struggle after a heated discussion between academic members and practical ones. The fact that an academic representative became the leader of the situation implied that oriental medicine understood and emphasised the academic importance of the conflict.

In the meeting, the leaders decided to translate all reference to the *IMS & Needle TENS* in English into Korean and then attack the key points that the IMS academic society in western medicine emphasised (Dr. G. in the Emergency Meeting of oriental medicine). They also made a plan to publish a textbook about their academic evidence, as well as to write a paper in order to persuade the government to accept their argument. Further, they discussed ways to reinforce their basic professional position in the meeting. On facing the crisis of oriental medicine, those at the meeting agreed that the position and the importance of acupuncture should be heightened within oriental medicine.

They deplored that, with 80% of oriental medical treatments covered by acupuncture, the subjects of acupuncture in the curriculum of oriental medical universities accounted for only 20% (Dr. H. in the Emergency Meeting of oriental medicine). A leader suggested that a department of Acupuncture should be established in oriental medical universities with the government's or the AKOM's support⁶³, in order to develop oriental medicine. As shown in the Emergency Meeting, oriental medicine needed an academic basis and emphasised its importance in facing western medicine over the issue of *IMS & Needle TENS*.

In the former conflict with pharmacy, the academic field of oriental medicine was not located in the leading group. Although academic members had also actively joined the conflict with pharmacy, the leading group had been mainly composed of oriental doctors in clinics. However, the representatives in the meeting realised that, for the coming conflict with western medicine, academic influence would be stronger in controlling this situation than it was in the first conflict. Close cooperation between the practical field and the academic field at the same latitude, or with rather higher latitude of the academic field, in the leading group of oriental medicine reflected a different type of conflict from the former one with pharmacy.

In the meantime, discussions about unification within oriental medicine emerged only in April 2003, by being stimulated by western physicians' strong argument. Although the bulletin board for the Association of Korean Oriental Medicine has been

⁶³ "There are other specialisations [in oriental medicine, in addition to Acupuncture], and they all would argue their own departments. Therefore, the establishment of a department of Acupuncture will not be achieved only by efforts of academic members in universities (Dr. J. in the Emergency Meeting)".

heated with argument over unification, the executives of the Association of Korean Oriental Medicine have neither suggested any policy nor organised any group to argue against unification. According to the post-interview of a leader in oriental medicine, oriental medicine has been “intentionally restraining itself” from facing western medicine and developing the situation. *OrientalDoctor4* implied that the leading group of oriental medicine believes in the government’s principle, that is, health care with two separate medicines.

As long as the government keeps its policy for the development of oriental medicine, we don’t have to come forward in the conflict. We believe we don’t need to respond to western medicine [with regard to the issue of unification]. (*OrientalDoctor4*)

7.4.2 Resources for and against Oriental Medicine

When it comes to organisational resources, such as the number of members and the amount of budget, oriental medicine is inferior to western medicine. Terms, practices and processes in oriental medicine are still too difficult to be understood by people. This made it difficult to communicate with people. It was political capacity, that is, well-defined lobbying protocol and public support, that oriental doctors owned as their strong point. The key leaders of oriental medicine interviewed had trust in the government and their lobbying process.

However they [western medicine] argue against us [oriental medicine], we’re going upstairs step by step with new policies for us. (*OrientalDoctor4*)

The following decisions related to political actions in the Emergency Meeting showed that oriental medicine follows their general lobbying process, as explained by a director of the Association of Korean Oriental Medicine with regard to the former conflict with pharmacy (pp. 88-90).

It was the time when the new government had just started. The Association of Korean Oriental Medicine executives were to meet the new Minister of Health and Welfare a week later, as would other important medical or social associations. In the Emergency Meeting, there emerged an opinion that the new Minister should be informed of the issue of *IMS & Needle TENS*, because those present worried that the Minister would sign the western physicians’ proposal without knowing its meaning and importance for oriental medicine. They agreed that it would be better simply to let the Minister know the importance of the issue along with other difficulties of oriental

medicine at the meeting with her. The oriental medicine representatives also decided to make separate documents for the Health Insurance Review Agency, the Ministry of Health and Welfare, and the press in order to refute the western physicians' arguments.

It is not confirmed how the leading group in oriental medicine accessed the government and persuade them in practice. However, the fact that the government delayed the decision and did not immediately accept the western physicians' suggestion implies that oriental medicine has so far defended their position well against western physicians.

Public support was what oriental medicine believed the most strongly. Oriental doctors never doubted that people would again be on their side.

The conflict between western medicine and oriental medicine is an ideological conflict [between traditional, or national, culture and western culture]. People will never abandon us (*OrientalDoctor1*).

Journalist2 also agreed with the oriental doctors' optimism on public support.

7.5 Role and Attitude of the Government

The government's principle was clear: health care with two different medical professions, western medicine and oriental medicine. While western medicine strongly suggested unification, the Minister of Health and Welfare commented that oriental medicine should exist separately from western medicine.

Since 1994, the Committee for Health Care Reform has recommended co-practice between western medicine and oriental medicine. In 1978, the World Health Organisation had recommended that traditional medicine should be combined with western medicine. Co-practice was the first attempt by the government to arrange the relationship between medical professions before any conflict arose. According to a government document, co-practice tended to increase either in western medical facilities or in oriental medical facilities. A report in 1999, which was referred to in the document (Ministry of Health and Welfare & Korean Institute for Health Care Industry Promotion, 2002), revealed that 60.9% of oriental medical facilities, 79 oriental hospitals among 130, employed co-practice. Although there was no data on co-practice in western medical hospitals, the case might be less than in oriental medicine. As shown in the data regarding the intention to learn the counter medicine (p.191), western medicine was less active in co-practice.

However, behind the statistical figures, western physicians and oriental doctors have been sceptical of co-practice. Even the administrative system does not allow western physicians and oriental doctors to co-practise in one space.

A medical facility and an oriental medical facility should be established separately according to a building regulation. Fees for medical services are also separately applied to western physicians and to oriental doctors, according to different fee systems in the National Health Insurance [and a patient should pay double]. Officially, the patient should come and go to see western physicians and oriental doctors. However, in that case, a patient repeats the process of hospitalisation and of leaving a hospital [to see a western physician and then an oriental doctor, or vice versa]. Therefore, hospitals use an expedient. Unofficially or illegally, western physicians and oriental doctors come to a ward for a hospitalised patient. .. but even in that case, the patient should still pay for all the processes of leaving the hospital and hospitalising again. (*OrientalDoctor1*)

Other interviewee also pointed out that hospitals use co-practice first for increasing their own financial benefits.

There are a few hospitals attempting co-practice. Some western medical hospitals employ oriental doctors and some oriental hospitals employ western physicians, but that's only a physical [external] combination, not a chemical [true] combination. Until now, it's been only for a financial reason (*OrientalDoctor3*).

The present co-practice is only for ... money. A hospital [with co-practice] can demand fees [from the National Health Insurance Corporation] for some parts from western medical fees, and for other parts from oriental medical fees. It's like... a large shopping centre with more diverse goods, but it's just a distorted way of practice. (*OrientalDoctor2*)

As far as I know, co-practice has been done only for a financial reason. (*WesternPhysician04*)

Nevertheless, the government encourages western and oriental hospitals to co-practise. That means the government plans to keep the present health care system with two different medicines. A recent series of schemes and plans in favour of oriental medicine also show that the government will admit the present medical system.

From a different perspective, the government might need two different medicines in health care in order to control them more effectively. The following comment from oriental medicine implies this.

The government is happy; because we can do something that western medicine cannot, such as lessening the use of antibiotics in western medicines. (*OrientalDoctor4*)

Based on the fact that, in recent years, the government has attempted to reform health care mainly by controlling western medicine, the existence of oriental medicine might be a card for the government to continue the reform.

Meanwhile, the government has not taken any side in the *IMS & Needle TENS* issue. In fact, the Health Insurance Review Agency delayed the decision to authorise it as a new medical treatment in western medicine, an action that made it appear as if the government would not take the side of western medicine. A key leader in oriental medicine reported the government's position and atmosphere to those at the Emergency Meeting as follows:

The government does not want to intervene in the conflict between the two medicines over *IMS & Needle TENS*. They seem to want to remove themselves from this trouble and then establish some foundations or data to evade it. (*OrientalDoctor4*)

There was a certain shade of meaning in the comment that the government is willing to employ data for its decision, especially if oriental medicine furnished any information – “even if the information is in favour of oriental medicine (*OrientalDoctor4*)”.

The government recently found a way to get out of the *IMS & Needle TENS* difficulty. On 7 July 2003, the government announced that in 2004 a new independent organisation would be established to judge and examine a new medical treatment. The decision on *IMS & Needle TENS* will not be set until the new organisation is in place.

7.6 Interpretation of the Conflict

7.6.1 Implications of the Conflict

The latest conflict between western medicine and oriental medicine only emerged in March of 2003. It would be bigger and more influential than any former medical conflicts, because the players are the most important medical professions. The two professions share the same jurisdiction with each other, that of practising medicine. Therefore, western physicians and oriental doctors are the keenest rivals, which would reveal the most serious jurisdictional conflict in health care. Different from the former cases, the conflict between western medicine and oriental medicine has different controversial points, which are addressed differently by the two professions. Oriental doctors focused

on protecting their monopolistic jurisdiction of acupuncture by facing the western physicians' argument for *IMS & Needle TENS*. This case implies that the National Health Insurance is emerging as new battlefield between medical professions. However, western medicine has attempted to push on with the more fundamental scheme of unifying western medicine and oriental medicine. It is a collision between scientific modern medicine and traditional medicine.

There are also monetary motivations behind the conflict. The two professions wanted to improve their financial difficulties by changing, or keeping, the existing jurisdictions. *IMS & Needle TENS* could be a new income source for western medicine. Unification would also cause an expansion of the market of western medicine, although there appear to be few possibilities in the nearer future.

7.6.2 Environmental Factors of the Conflict

7.6.2.1 Internal Factors

From the organisational perspective, the conflict between oriental medicine and western medicine was individually the second one for both medicines. Each had undergone internal reform with a shift in generations and organisational modernisation with their first conflict. With this conflict, both professions showed different attitudes, based on what they had learned in their earlier experience of conflict. The actions of the Korean Medical Association and the Association of Korean Oriental Medicine were more mature and better-organised than in their first conflict. Most of all, they individually attempted to find academic and rational foundations for their arguments, instead of relying on radical actions, as before. They attempted to use their own academic societies and accumulate professional evidence to gain advantage in the conflict.

It is difficult to say if there is an internal stratification and dominant power in the relationship between western medicine and oriental medicine, because, from the legal perspective, western physicians and oriental doctors are all doctors. Western medicine has a stronger influence over oriental medicine in their relationships, whether in the manpower and the capital or in professional knowledge. On the other hand, from the government and public opinion, western medicine obtained less support. Therefore, western physicians would not make situations only favourable to them.

7.6.2.2 Cultural Factors

A new factor outstanding in the conflict has been a change in the professional knowledge system (Abbott, 1988: 177-184). Alternative medicine emerged as new practices in

western medicine in Korea, although there were old practices of oriental medicine consistent with them. Over the origin and right of a specific practice of alternative medicine, such as *IMS & Needle TENS*, the two professions faced each other. Abbott argues that the development of new knowledge or skill may consolidate jurisdictional hold or may facilitate expansion at the others' expense (Abbott, 1988: 96-97). Although it is difficult to assert in Korea whether alternative medical practices are based on new or old medical knowledge, it is clear that alternative medicine is changing the existing knowledge system in Korean health care. Therefore, alternative medicine in Korea can be discussed from Abbott's argument.

The appearance of alternative medicine made oriental medicine consolidate, not only organisationally but also academically. To protect their important jurisdiction of acupuncture, oriental doctors attempted to provoke the solidarity of members again, as in the former conflict with pharmacy. In addition, to compete with western physicians' argument for alternative medicine, oriental doctors made more efforts to find their original foundations of oriental practices. In contrast, western physicians attempted to accept alternative medicine only that had not lost its scientific medical form. Alternative medicine would allow western medicine a new jurisdiction, as Abbott argued. However, alternative medicine has not required any additional expenses, different from Abbott's expectation. Western physicians can only extend the scope of their practices by increasing the number of medical services. In addition, the appearance of alternative medicine has given western medicine a foundation of the argument for unification.

The conflict also provoked a controversy between the two professions and among oriental doctors about the legitimacy of medicine. Western countries in the 19th century had emphasised science for the legitimization of professional activities (Abbott, 1988: 189-190). Not very different from that, western medicine in Korea has specifically attacked oriental medicine with this issue, arguing that medicine should be scientific and evidential, while oriental medicine has been divided into groups with different opinions on scientisation. This was the first time the two professions seriously argued for their professional legitimacy and against others. Before then, they had mainly criticised others on an emotional level. Although there are still emotional reactions, the controversy on scientific medicine arose on the surface as a conflict between western medicine and oriental medicine.

7.6.2.3 Other Environmental Factors

Technology was an important social factor that was more controversial in oriental medicine. Although oriental doctors argued for their superiority in medical knowledge,

not a few young oriental doctors wanted to use scientific medical equipment in western medicine. In the Korean case, the younger oriental doctors, the government and oriental medical institutes actively attempted to introduce scientisation and to use scientific technology. It was different from western cases, in which professions have been influenced by the general development of science and technology. Because of some oriental doctors' active attitude for technology, the conflict between the two professions and then the internal conflict in oriental medicine became severe.

With regard to social or political attitudes in Korean society, the conflict is a war between the rationalism or science of western medicine and the traditional heritage or nationalism of oriental medicine. In the conflict between the two professions, the government and the political field appeared to be on the side of oriental medicine. Although, from a purely professional perspective, rationalism and science are important, the political ideology of the people does not easily give up the traditional heritage and oriental medicine. In particular, the recent political and international atmosphere stimulates more strongly the nationalism of the people⁶⁴. Nevertheless, western medicine has been steadily preparing the foundation to attack *non-scientific* oriental medicine and to reveal their professional superiority in practising medicine.

Lastly, international situations and tendencies emerged as another influential factor for the first time in this conflict. The tendency toward alternative medicine in western countries was the one and another was international 'pressure' on the present Korean medical system with western medicine and oriental medicine. The Korean health care market will open in 2006, according to the World Trade Organisation Agreement. To respond to the changing international situation, the government and leading groups in the two professions have already had discussions. Oriental medicine was concerned about its changing situation. Although they had confidence that they would exist independently from western medicine with the government's support, oriental doctors were uncertain with regard to opening the medical service market. Government officials had also commented that there would be room for reconsideration of the present medical system, if the situation became difficult with the opening of the health care market. In 1978, the World Health Organisation already recommended that traditional medicine in every country should be combined with western medicine. It became an important foundation for a co-practice policy by the government and the argument for unification by western medicine. Therefore, the international situations and pressures were seen as being able to change Korean health care and then jurisdiction of the two professions.

⁶⁴ As the influence of the conservatives has become stronger in the US since 2001, anti-Americanism and nationalism have become stronger in South Korea.

7.6.3 Who Regulated the Conflict?

7.6.3.1 Claiming Sole Jurisdiction in Different Arenas

Western medicine and oriental medicine claimed their own jurisdiction in the following different arenas, as Abbott suggested: the legal arena, public opinion, the workplace and academia.

A feature of this jurisdictional conflict, which is totally different from the other conflicts in Korean health care, is an academic one. Academia has emerged as a new and important arena where the two professions collided with each other. Both professions have been collecting academic foundations for their arguments, because the present law requires an academic basis for admitting a jurisdiction for a medical profession. Neither profession can just use the political strategies and collective actions that they used to win in the former conflicts. There was a similar academic tendency in the former conflict between western medicine and pharmacy and the two professions mobilised academic methods in preparing their documents. However, their research was not used to suggest their professional right or foundation, but to estimate their financial loss from the separation system and then to calculate the compensation for it. In contrast, in this case of *IMS & Needle TENS* and unification, the two professions have focused on finding and developing academic foundations to argue their jurisdiction.

In the legal and administrative arenas, oriental medicine has an advantage. The government has announced schemes to develop oriental medicine and has also declared that the two different medicines will exist independently. So far, in the legal arena, the government has supported oriental medicine, and western medicine has appeared to lose.

In the arena of public opinion, the issue has not stood out clearly, because it is still the beginning of the conflict. There was a debate on *IMS & Needle TENS* on the radio, but the public did not appear to pay attention to it. The arguments presented were too complicated for the public, who only recognised that there was *another* conflict between western medicine and oriental medicine. In practice, the two medicines showed equal strength. Western medicine gained professional trust from the public for its evidence-based knowledge and scientific technology, while patients with a particular disease, such as paralysis, and the old believed in the efficacy of oriental medicine. However, if the conflict were revealed to the public more clearly, it would be difficult for western medicine to obtain support from them. The existing image of western medicine is not favourable to the public and oriental medicine as a national heritage still has strong public support.

In the workplace, the two professions have seldom met and faced each other, except for those in only a few hospitals for co-practice. Each has criticised the other about making patients worse, as shown in oriental doctors' comments during interviews and in western physicians' articles on the website of Health & Science Korea. Therefore, conflicts between western medicine and oriental medicine in the workplace are rare.

7.6.3.2 Role of the Government

In the case of conflict between western medicine and oriental medicine, the government has shown a more consistent and strong role than in any other cases, perhaps because the issue is in its early stages and other groups' interests and reactions are not yet developed. The fact that the issue could cause a huge and general change in health care may require the government to be cautious and consistent.

Over the issue of *IMS & Needle TENS*, the government has delayed a decision until 2004, which means that until then, the argument of oriental medicine remains stronger. However, western physicians can still use *IMS & Needle TENS* in the name of study as a non-insured practice. When the new organisation to judge jurisdictional conflict between medical professions is established, the government will make its position on this conflict clearer.

Currently, the government clearly supports keeping two different medicines and encouraging co-practice in medical facilities. Co-practice between western medicine and oriental medicine was the first case in Korean health care in which the government attempted to settle a conflict between medical professions before it broke out externally. Although not very practical in the workplace, co-practice is still encouraged by the government and used to block western physicians' argument for unification. Because other groups and arenas have not yet shown any concern about the conflict between western medicine and oriental medicine, the government appears to be leading and controlling it.

7.6.4 Conclusion

In the conflict between western medicine and oriental medicine, western physicians attempted to develop it into unification of the two professions, the most serious jurisdictional conflict in Korea. However, oriental medicine kept it confined to the specific jurisdictional issue of *IMS & Needle TENS*. Western medicine attempted to expand their market, as well as to make their professional jurisdiction of practising medicine monopolistic, in terms of unification. In contrast, oriental medicine intended to keep their specific professional jurisdiction of acupuncture, assuming and believing that

their independent professional position should/would be kept. Behind the professional issues, there were also economic motives for both to be released from financial pressures in the health care market.

There were diverse and different factors, which influenced this latest and potentially biggest conflict. Different from the former conflict, tension developed in academia over efforts to find a foundation for their jurisdictions. This suggests that both professions might have changed their strategy from direct collective actions to a rational and academic one. The legitimacy of a medical profession, which according to western medicine is science, also emerged as a new factor. Over the issue of using technology, oriental doctors showed different opinions, particularly between generations. Most of all, a change in the knowledge system of health care, which emerged with the appearance of alternative medicine, was another influential factor.

The environmental factors above are mostly, although not specifically, explained by Abbott (1988). However, there is another factor not applied in Abbott's theory. International economic pressure appeared as a direct and important factor for the first time in the Korean case. Opening the health care market was the only possible force able to change the present policy of the government and the people's support of oriental medicine, which stemmed mainly from nationalism. For the public, this conflict was a collision between social values of rationalism based on science and nationalism based on national heritage.

The government's clear attitude toward the two professions strongly influenced the conflictual situations. Oriental medicine kept their ascending current of development according to the long-term development plan and public commitment guaranteed by the government, which had mainly resulted from their first conflict with pharmacy. In contrast, western medicine had difficulty in persuading the government to accept their arguments, since the government still considered western medicine one to be reformed.

In the mean time, the controversy over *IMS & Needle TENS* suggests that the National Health Insurance is emerging as a new battlefield between medical professions. Because Korea introduced a compulsory health insurance scheme, determining which medical services would enter the National Health Insurance became important for medical professions. Conflict among medical professions in the NHI is discussed more specifically in the next chapter.

CHAPTER 8. CONFLICT AMONG THE THREE MEDICAL PROFESSIONS OVER THE NATIONAL HEALTH INSURANCE

In this chapter, the fourth case looks at the conflictual relationships among western medicine, oriental medicine and pharmacy in the National Health Insurance scheme. As in the case of *IMS & Needle TENS* discussed in the previous chapter, the NHI has already become a new field of conflict between medical professions. A more direct conflictual issue in the NHI occurs when medical professions compete with each other to obtain more shares of the fund. This issue is less known to the public, but it is more sensitive than any other case in Korean health care.

The conflict in the NHI has a particular meaning for individual medical professions. The three main medical professions had twice experienced individual conflict with each other, as shown in the previous three chapters. However, except in the NHI, they had never faced each other at the same time. Therefore, relationships among the three professions are examined in this chapter, giving further information about and implications for the medical professional system.

It is important to consider that the present system of setting fees for medical services, which strongly influences the level of fees, was introduced during the second conflict, which occurred between western medicine and pharmacy over the separation system. Therefore, setting fees in the NHI might still reflect those circumstances and the policy direction existing during that second conflict in Korean health care.

This chapter starts with types of conflict over the National Health Insurance. Among the types, focus is given to conflict among the medical professions to obtain more share of the NHI. Then, how the NHI conflict, unlike the other conflictual cases, caused different relationships to exist among them is analysed. Strategies and the political capacity of individual professions regarding the NHI provide even more information on them than in the previous cases. How the government has controlled medical professions in the NHI is also discussed.

8.1 Background

Since 1993, there have been three conflicts between medical professions in Korea: one between oriental medicine and pharmacy over preparing oriental medicines; one between western medicine and pharmacy over the separation scheme; and one between western medicine and oriental medicine over unification. The former two conflicts were fierce and the last one is expected to be no less so. Compared with all of them, the conflict over the National Health Insurance did not attract public attention, because it did not quite reveal

what happens in the decision-making process of the NHI, and because the topic was too complicated for the public, filled with statistical figures. Although less known to the public, the National Health Insurance is an important arena, where dynamic and complicated relationships between medical professions are found. According to a government official, setting fees for medical services is hidden but it is the most sensitive topic as the starting and ending points of all health care issues (*GovernmentMember1*). While the former three conflicts show individual concerns between two professions, the conflict over the NHI would reveal how the three professions relate to each other.

8.1.1 Types of Conflict over the National Health Insurance

During my fieldwork, I identified three kinds of conflict over the National Health Insurance. One is internal conflict, which matters within a medical profession and the other two are external ones with other medical professions.

The first one emerged within a medical profession over whether a medical service should be insured or not. The best example was prescribing and preparing oriental medicines. That was not yet insured, but there was animated discussion about it within oriental medicine.

Most of the income for non-insured oriental medical services comes from prescribing and preparing oriental medicines, which implies that the service is the most important income source for oriental doctors, particularly while fees for insured services are low. Therefore, oriental doctors with their long-standing clients are not happy about insuring the service of preparing oriental medicines. However, young oriental doctors want the service to be covered by the NHI⁶⁵ and expect that the lower fee in the NHI will increase the number of patients and the demand for preparing oriental medicines.

Leaders of oriental medicine, who are younger than ever before, have also realised that increasing the number of clients in oriental medicine itself is the most important task for their whole profession. They believe that oriental medicine has had to ride the National Health Insurance in any case, in order to survive in the medical system (*OrientalDoctor4*). In addition, to make their income source clearer and then to obtain public trust, oriental doctors are needed to apply for preparing oriental medicines in the NHI (*OrientalDoctor3*). Nevertheless, the Association of Korean Oriental Medicine has not yet officially applied to the government for the service to be covered by the National Health Insurance. The main external reason has been the deficit of the NHI, but there

⁶⁵ According to a survey (AKOM, 1997: 30-31), the number of respondents for *positive agreement* on insuring the preparation of oriental medicines was significantly different by age: 50% for the 20s, 49% for the 30s, 35% for the 40s, 28% for the 50s and 19% for the 60s.

might still be the influence of the old and vested group in oriental medicine, which has demanded more consideration for the decision.

The second conflict over the NHI broke out when a medical profession attempted to get one of their treatments covered by the health insurance scheme. If a similar medical treatment by another medical profession already exists in the NHI, the situation could develop into a jurisdictional conflict between the medical professions concerned. The latest conflict between western medicine and oriental medicine over *IMS & Needle TENS* is an example, as shown in the former chapter. This case suggests that jurisdictional conflict will break out in the NHI. Because the Korean government introduced a compulsory health insurance scheme, medical professions acknowledged that the key to survival in the medical system is, after all, to let their services be covered by the national health insurance.

A third type of conflict over the National Health Insurance system emerged when medical professions recognised the importance and necessity of their strategy in the NHI to increase and keep their own share of the insurance fund. Medical professions mainly had faced the representatives of the payers and/or the government. During the former conflict over the separation system, the government had appeased medical professionals by increasing fees for medical services in the national health insurance. Although medical professionals knew that the government's strategy was a temporary expedient, they could not deny that the increased fees eased the financial difficulties they experienced in managing their medical facilities. In the last two years, however, fees have decreased because of serious financial deficits of the NHI. Medical professions then recognised that the National Health Insurance would be another battlefield in the health care system. This third type of conflict within the NHI scheme will now become the main topic.

8.1.2 Setting Fees in the NHI

As presented in the chapter on Introduction to Korean Health Care (pp. 30-31), in 2000 during the conflict with western medicine and pharmacy, a new repayment system and a contract system were introduced. With the failure to reach agreement in the contract system, the Health Insurance Policy Deliberation Committee now decides fees in the National Health Insurance by deciding the monetary value per unit of medical services. The Committee consists of the following three groups.

- 8 Representatives of the Supplier Group from western medicine, oriental medicine, dental surgery, pharmacy, nursing and pharmaceutical corporations,

- 8 Representatives of the Payer Group (the insured and insurers) of the national health insurance from trade unions, management unions, influential vocational groups and civil pressure groups and
- 8 Representatives of the Public Interest Group from the government, NHI Corporation, Health Insurance Review Association, national health care institutions and academic fields

Representatives of the Supplier Group always attempt to increase their payments from the National Health Insurance or avoid curtailing them. Payer Group representatives attempt to cut down medical professionals' fees as much as possible and increase the contribution rate as little as possible. In the middle of these two poles, representatives of the Public Interest Group attempt to mediate the different arguments. By controlling the level of fees, those representing the Public Interest Group attempt to contain medical expenditure. Most of all, the first purpose of the Health Insurance Policy Deliberation Committee is stabilising the financial conditions of National Health Insurance. Therefore, medical professions have not avoided curtailing their fees under the Health Insurance Policy Deliberation Committee.

Within the Committee, all representatives do their best to achieve their own purposes, and every meeting has been 'a fierce battle' among different groups. Comments made by interviewees who attended the meetings of the Health Insurance Policy Deliberation Committee as representatives of individual groups showed *how hard the meetings were*.

You'd never imagine how stressful the meetings are. At the last round, it's almost a test of physical strength. (*WesternPhysician01*)

It made the representatives totally exhausted to the last drop of perspiration. I kept in my mind the awareness that my own judgement or decision would influence all pharmacists' income, and I tried to persuade other representatives. If not, I was devoured by them. I could not turn my eyes at any moment. (*Pharmacist4*)

A hard schedule must have been the government's strategy to push the Committee to make a quick decision, and government officials must have possessed some skills to manage the situation. (*Pharmacist3*)

As identified in internal documents, the average meeting time⁶⁶ was 3 hours and 48 minutes. Of 24 meetings, 13 started in the forenoon and, particularly, 9 meetings started at 7am or 8am. In addition, 11 meetings of 24 intensively opened in November

⁶⁶ It was for 19 meetings. There was no record about the end of meetings for 5 other meetings.

right before the deadline. Based on these data, those present must have seen those meetings as ‘extremely hard tasks’.

The Supplier Group and the Payer Group were all dissatisfied with the system of deciding fees in the National Health Insurance. The Supplier Group particularly opposed the present structure. At the last meeting to decide the fee for medical services in 2002, seven representatives walked out or refused to vote or to accept the decision of the Health Insurance Policy Deliberation Committee.

The law, which specified the structure of the Health Insurance Policy Deliberation Committee, had a problem. We need a rational one in the number of representatives. The law should be revised. Though the representatives of the Payer Group and the Public Interest Group have their own arguments, basically, there’s something wrong with people’s consciousness. The contribution [in the national health insurance scheme] is for oneself, but people seldom want to pay for it. (*WesternPhysician09*)

The present structure of the Health Insurance Policy Deliberation Committee increased doctors’ distrust of the government.

All intention of the government is to impute the deficits of the NHI to doctors. “Let’s take doctors’ and divide them.” That’s the government’s intention. (*WesternPhysician14*)

We have continuously demanded revision of the law and regulation of the process, representatives and scope in deciding fees. However, the government is indifferent to our demands. (*WesternPhysician01*)

Under the present structure, a so-called strategy is meaningless. There’s no other way but fighting. (*WesternPhysician10*)

The Health Insurance Policy Deliberation Committee would break, since representatives think the government only makes them foils. And... actually it does, as it wants. (*Pharmacist3*)

GovernmentMember4 agreed that there was a problem with the structure of the Health Insurance Policy Deliberation Committee. However, he doubted that the Health Insurance Policy Deliberation Committee would change before long, because it is a legal organisation and changing its structure would require a complex legal and political process (*GovernmentMember4*).

8.2 Relationships among Groups in the National Health Insurance

Actions and situations in the process of setting fees in the NHI have been hard to discover, because only those on the Health Insurance Policy Deliberation Committee and the government officials concerned in the Ministry of Health and Welfare know them. The interviews with those people and internal documents give information about what has been done in the NHI, and how.

8.2.1 Conflict between the Supplier Group and the Payer Group in the NHI

The main conflict in the Health Insurance Policy Deliberation Committee meetings occurred between the medical professional representatives and the payer representatives. The internal documents of the Health Insurance Policy Deliberation Committee and the interviewees' comments show that. In particular, the conflict between the representatives of western medicine and the representatives of the trade unions was the most vigorous and ubiquitous through 24 of the Health Insurance Policy Deliberation Committee meetings in 2002. Debates between them were always serious, only if both players were present at meetings.

According to internal documents, representatives of the Korean Medical Association left the meeting room before the close of the meeting in the three most important meetings. The first controversial issue was deciding how and by whom the research on the monetary value per unit of medical services would be done. At the 11th meeting, representatives of western medicine doubted the objectivity and impartiality of the candidate research team and their method. They finally refused to vote and left the meeting room. The second issue was to pass the reform bill of reimbursement. At the 16th meeting, the KMA representatives strongly opposed reducing fees for medical services and walked out with the representative of pharmacy. At the 23rd meeting, they also declined to vote on the monetary value per unit of medical services and new contribution rate, because the increased rates in the final alternative were far from their suggestion. In addition, on seven occasions, representatives of the Korean Medical Association did not attend meetings, apparently to express opposition to the disadvantageous and uncontrollable atmosphere of the meetings.

The purpose and attitude of the Payer Group representatives were clear and firm.

Since the separation system, the number of newly established clinics has increased. That is evidence that medical facilities have gathered huge amounts of money through the separation system⁶⁷. ... I must say that we

⁶⁷ Against this argument of the Payer Group, western medicine refuted that 3,300 doctors are newly produced every year and that they have to use all their financial resource to open clinics

should limit the payments for western medicine to support financial stabilisation in the National Health Insurance. (A representative of the Payer Group in a meeting of the Health Insurance Policy Deliberation Committee)

Other representatives, especially of the Supplier Group, worried about that strong attitude of the Payer Group. According to the interviewees from other representative groups, Payer Group representatives did not want any negotiation or any arrangement in the Health Insurance Policy Deliberation Committee.

Once, we had a meeting for 7 hours. And the result of the meeting was... you know what? 'We'll open a meeting again tomorrow afternoon.' That was all. At that time, before deciding an important item, western medicine needed time to let their members know it and get their agreement. For that, they needed another meeting and some time, at least a day. However, the representatives of trade unions rejected that request and wanted to make a decision about the item on the spot. So, we had to spend seven long hours squabbling about another meeting vs. no more meeting, and then about whether we would meet in the morning or in the afternoon. (*A representative of the Public Interest Group*)

Based on internal document of the Health Insurance Policy Deliberation Committee meetings, the representatives of the Payer Group also left meetings before the end on three occasions. The 6th meeting was to decide by how much the fees for medical services and the contribution rate should decrease. They opposed the arbitrated proposal suggested by representatives of the Public Interest Group. The second departure by the Payer Group representatives occurred at the 9th meeting, right before the individual medical professions reported their difficulties, implying that representatives of the Payer Group did not want to listen to the Supplier Group's suggestions and arguments. At the 23rd meeting, the Payer Group representatives declined voting to decide the monetary value per unit of medical services and the new contribution rate, only as the medical representatives had done. They were also displeased with the final alternative suggested by the Public Interest Group, because they wanted a much lower contribution rate and a much larger decrease in fees for medical professions. At the 21st meeting, the Payer Group representatives distributed their statement to the press, criticising the attitude of the representatives of the Supplier Group and the Public Interest Group before the final decision about the new contribution rate and new fees for medical services.

The conflict between the Supplier Group and the Payer Group influenced the relationship between medical professions. Facing the common opponent, the medical

(A meeting of the Health Insurance Policy Deliberation Committee, 2002).

professions showed a cooperative relationship, although there still remained a conflictual undertone.

8.2.2 Conflict among Medical Professions in the NHI

According to the interviewees, there was conflict between medical professions in the NHI. “Over the limited pie”, medical professions had to compete with each other to obtain a bigger share. In the Relative Value Points Evaluation Team, a sub-organisation of the Health Insurance Policy Deliberation Committee, relative value points for individual medical services are examined. Reviewing every value point of medical services used to be done by external study. The Relative Value Points Evaluation Team examined the studies and arranged value points. During the meetings of the Team, medical professions kept each other in check not to let opposite players take a larger share of the pie.

The following comments from a professional representative reveal a strategy to check other medical professions in the NHI.

There is a case in which the government attempts to give a NHI benefit to a certain medical profession by increasing fees or insuring a new medical service. As a reaction, other medical professions leak the information to the representatives of the Payer Group and the press in advance. At the same time, the medical professions protest to the high government officials responsible for the case about their unequal treatment. If the protest does not work, medical professions appeal to higher government officials. However, in most cases, the final purpose of the check is obtaining the same benefit from the NHI (*OrientalDoctor4*).

The conflict among medical professions on the Relative Value Points Evaluation Team appeared to be delicate and implicit, not open or explicit. Medical professions did not openly criticise or oppose each other, because they would return to the main meetings of the Health Care Policy Deliberation Committee again as colleagues, in order to increase or freeze the monetary value per unit point of medical services. However, in the meetings of the Relative Value Points Evaluation Team, they still checked other medical professions’ arguments by suggesting different opinions and ask delicate questions.

The following comments give an example of implicit conflict between medical professions in the Relative Value Points Evaluation Team.

In a report, a national institute estimated that working hours of hired pharmacists and those of owner pharmacists are the same. As you know, that’s absolutely wrong. Although we [owner pharmacists] worked until midnight before, now we work until 9 to 10pm. Even though physicians acknowledge this, they don’t support our argument against the miscalculation in the report. It is the same in a medical case. [In the

Team meetings,] Western physicians [representatives of western medicine] argue that the research overestimates the proportion of their income from non-insured medical services. [If the proportion is large, western physicians are disadvantaged in deciding fees for medical services in the National Health Insurance]. In this case, we [pharmacy] do not actively support western physicians, although we do not strongly oppose them, either. (*Pharmacist4*)

As shown above, conflict between medical professions in the NHI was less marked than that between western medicine and the payer representatives. Nevertheless, behind the strong conflict between western medicine and the payer representatives, medical professions still attempted to check others and to obtain more shares for themselves. In addition, the Ministry of Health and Welfare has recently attempted to focus more on reviewing and arranging individual relative value points for medical services than on deciding a monetary value per unit of medical services⁶⁸. Therefore, conflict among medical professions in the NHI will appear to be more and more strong.

8.2.3 Cooperation among Medical Professions in the NHI

With the strong conflict with Payer Group representatives, medical professions cooperated with each other as colleagues. They all faced the attack of the Payer Group and the Public Interest Group. The medical professions appeared bound to assist each other to increase fees for medical services and avoid reductions. That is why, at least in the Health Insurance Policy Deliberation Committee, the relationships among medical professions had a distinct leaning toward cooperation, rather than conflict.

After all, we have the same position as the supplier of medical services in the Health Insurance Policy Deliberation Committee. Therefore, some times we openly cooperate with each other and other times we strategically divide and play our role to stop decreasing fees in the National Health Insurance. (*OrientalDoctor4*)

Even in the case of conflict between medical professions in the NHI outlined in the previous section, a shade of cooperation between them could be found. After prohibiting a certain profession from obtaining a particular benefit by leaking information to the press and Payer Group representatives or by pressing government officials not to pass the benefit, according to a representative of the Supplier Group, medical professions pressed or asked for cooperation with other professions in obtaining the benefits.

⁶⁸ Minister of Health and Welfare Kim Hwa-Jung stated in an interview that deciding how to revise the unequal allocation of the NHI fund to different suppliers would be more important than increasing a monetary value per unit of medical services (DailyPharm, 2003).

A strategy for medical professions to obtain larger shares in the National Health Insurance would be presented as follows:

- (1) Medical profession *A* has a word from the government to obtain a new benefit.
- (2) Other medical professions attempt to check the special benefit by using the Payer Group or the press.
- (3) Other medical professions then complain to government officials about unfair treatment and ask for profession *A*'s cooperation in supporting their demand.
- (4) All, or at least the main medical professions, obtain the benefit together.

There is another example of cooperation among medical professions. In a Health Insurance Policy Deliberation Committee meeting, a report stated that income from non-insured medical services in Internal Medicine reached over 40% of its total income, although the representative of western medicine argued that it was not over 20%. Based on the report, the representatives of the Payer Group and the Public Interest Group in the Health Insurance Policy Deliberation Committee attempted to curtail fees for medical services. They argued that, according to the statistical figures in the report, western physicians are compensated for their loss from low fees in the National Health Insurance by their non-insured income. Then, other representatives of the Supplier Group, such as oriental medicine and dental surgery, opposed their attempt to cut down fees for medical services.

“If you curtail fees for western medicine, we’ll also oppose your decision. ... We can make one alternative, such as an average of fees of all medical professions. There is no reason for the Health Insurance Policy Deliberation Committee to attack only western medicine.” We were hugging western medicine as a colleague. Then, representatives of the Payer Group and the Public Interest Group could not oppose our argument and our alternative. (*OrientalDoctor4*)

As in the example above, there were cases in which advantageous or less disadvantageous suppliers took the side of the most vulnerable medical profession – mainly western medicine in the National Health Insurance. However, that help required a condition as a kind of saving for the future.

Then, we never forget that we helped a medical profession and that there would be a time when we would also need help from ‘the’ profession. (*OrientalDoctor4*)

There is another example of a “good relationship” between medical professions in the National Health Insurance, one which implied a different type of strategy. In October 2002, the Health Insurance Policy Deliberation Committee decided to integrate the divided fee systems in western medicine. There had been four groups⁶⁹ of specialities in western medicine before then, to which different fees had applied in the National Health Insurance. By integrating into Group B, Group A would suffer a loss. To compensate for Group A’s loss, an alternative was selected in the Committee: the long-term care fee for chronic patients.

After arranging and deciding all those things, we [oriental doctors] and dentists argued that we also needed the long-term care fee. Then, at last, we obtained an agreement with other representatives. The western medicine representatives could not help agreeing with us, because they received the long-term care fee owing to our agreement.
(*OrientalDoctor4*)

The examples above show the following strategy used by medical professions to obtain a larger share in the National Health Insurance. The process is as follows:

- (1) As an arbitrator between a medical profession *A* and other representatives, medical profession *B* suggests an alternative, a new fee for an item in the NHI, and lets *A* demand it.
- (2) *B* supports *A* to obtain the new fee.
- (3) Then, *B* also argues that they need the new fee. At this time, *A* agrees with, or at least does not disagree with, *B*.
- (4) All or at least the main medical professions obtain the new fee together.

In most cases, medical profession *A* at the front of the suppliers is western medicine, and it is attacked most severely in the Supplier Group by the Payer Group. “Hiding behind western medicine”, other suppliers keep their share in the national health insurance. Although being indignant at this situation, western physicians accept ‘this absurd system of deciding fees in the NHI’, in which there are “only” two representatives of western medicine among 24 members of the Health Insurance Policy Deliberation Committee.

⁶⁹ *Group A*, applied to the highest medical fee, included Internal Western medicine, Psychiatry, Paediatrics, Family Western medicine and Tuberculosis. *Group B* did the Surgery circle, O & G, Dermatology, Ophthalmology, Urology and Rehabilitation Western Medicine. *Group C* did support medical circle and others such as Diagnostic Radiology, Nuclear Western Medicine, Preventive Western Medicine or Dental Surgery. *Group D* included Emergency Western Medicine.

8.3 Strategy and Political Capacity of Western Medicine

In the Korean Medical Association, the position of the Bureau of Health Insurance has been high. The vice-president took charge of the work and was the only full-time director in the Korean Medical Association executive until 2001⁷⁰. However, after the beginning of the conflict with pharmacy over the separation system in 1999, all capacities and resources of the Korean Medical Association were mobilised only to face pharmacists and the government.

In addition, the structure of the Health Insurance Policy Deliberation Committee was not favourable to western medicine. Among 8 representatives of the Supplier Group, three representatives belonged to western medicine, although over 60% of the payments in the NHI were allocated to western medicine. Among the three, one was a representative of the Korean Hospital Association and two belonged to the KMA. As the two medical associations did not show the same opinion during the conflict over the separation system, neither did they in the Health Insurance Policy Deliberation Committee.

While representatives of the Korean Medical Association actively struggled with the government's and the Payer Group representatives' attempts to curtail fees, the representative of the Korean Hospital Association did not appear to do so very enthusiastically. Although *WesternPhysician01* did not openly criticise the KHA, his following comment shows that he did not regard the KHA as the KMA's friendly force. During the interview, I said to *WesternPhysician01*,

I heard that you [the representatives of the KMA] and the representative of the KHA are sometimes... compelled to leave the Committee meetings even before endi...."

He hardly waited for the ending of my comment.

Not the KHA. Never did the KHA walk out of the meetings. We, the KMA, took the lead in everything, pushed the Health Insurance Policy Deliberation Committee to decide correctly, and left meetings. WE did. ... The KHA is the group for managers, not doctors. KHA's thoughts and attitudes are not the same as ours. (*WesternPhysician01*)

In attempting to increase and, now, keep fees for medical services in the National Health Insurance, the representatives of the Korean Medical Association feel understaffed

⁷⁰ Since 2001, the number of full-time directors of Korean Medical Association increased up to six.

and under-resourced in the KMA and in the Health Insurance Policy Deliberation Committee.

During the fieldwork, I found that most western physicians do not concentrate on the issue of the National Health Insurance. After the separation scheme was enforced, the fee for medical services in the NHI became a more important income source for western physicians. Therefore, increasing fees had to be one of the most important tasks of the KMA. However, it was not. I asked an important person in western medicine what kind of strategy the KMA used to increase the fee. His answer was surprising.

Western physicians' strategy to raise the fee for medical services? It's unnecessary. In 2000, Minister Choi announced in a special statement that... "The present fee is only 70% of the cost. It's completely unreasonable. The more western physicians practise, the more they suffer a loss..." Then he promised that the government would compensate western physicians for the loss. There was even a time schedule for the compensation plan. Until September 80%, after that 90% then 100%... like that. But it has not been kept. Under this situation, what kind of weapons are needed? The Minister, a Minister of the Republic of Korea, announced that the present fee was less than the cost and promised to compensate for it. We don't need a particular strategy (*WesternPhysician14*).

This kind of reaction by western physicians to the NHI was more than I had expected. As shown in Chapter 2, there was a case in which doctors had sacrificed their medical right and system for medical fees in the NHI. Nevertheless, there was no particular strategy to increase "such important" fees in western medicine. They only expected that the government should and would raise the medical fee "naturally".

The western physicians' strategy to manage medical fees was particularly poor at the beginning of the conflict over the separation system. An interview with a leader of a civic pressure group, *CivicGroupLeader3*, shows the point. He recalled "how poorly prepared the western medicine report was" about their loss and expecting compensation for it under the new separation system. That was when civil pressure groups were leading the 5.10 Agreement in 1999.

At that time, even the government did not have any proper data about financial changes in the NHI and in the medical professionals' income from the enforcement of the separation system. Western medicine and pharmacy were individually requested to estimate their own anticipated financial results from the separation system. Each financial paper from western medicine and pharmacy would be important in deciding fees for doctors and pharmacy. Nevertheless, the paper from western medicine was crude and seemed to be groundless. (*CivicGroupLeader3*)

However, interviewees agreed that the preparation and strategy of western medicine for managing the issue of medical fees has developed remarkably since the conflict over the separation system.

After learning from the disturbance over the separation system, western medicine was quickly organised. Until 1999, we were the best at preparing documents and other managerial processes, but now, we can hardly catch up with western medicine. The KMA now invests over 3,000 million Won [£ 1.5 million] in research and study [of policy] each year. Actually, in the manpower, we cannot follow them. (*OrientalDoctor4*)

A government official also agreed that the Korean Medical Association rapidly developed in how they respond to a policy or the government, using their changed and well-prepared organisation (*GovernmentMember4*).

In the meantime, western physicians show a strong antipathy to fees for pharmacists in the National Health Insurance, which reflects their attitude toward pharmacy from the former conflict over the separation system. They argue that the government pays pharmacists not for any professional service, but only for “a simple and mechanical service of wrapping medicines”. Western physicians blame pharmacists and the government for the financial difficulties of the National Health Insurance.

Do they do anything for 3,000 Won [£ 1.5]? Before the separation system, when we gave [prepared] medicines to patients, our fee for guiding patients in taking medicines was only 150 Won [7.5 pence]. Why are there NHI deficits now? (*WesternPhysician05*)

In setting fees in the Health Insurance Policy Deliberation Committee, western medicine struggled hard. The toughest partners they had to face were the 8 representatives of the Payer Group. The main purpose of the 8 representatives of the Public Interest Group was also to cut down the financial deficits of the National Health Insurance and decrease fees for medical services. Other 6 representatives of the Supplier Group ‘only attempted to increase or protect their own benefits’. It was hard for western medicine to change those hard situations into ones favourable to them.

The organisational structure of the Health Insurance Policy Deliberation Committee itself made it difficult for western medicine to manage its health insurance policy. Western medicine and its argument was the main target in the Health Insurance Policy Deliberation Committee. Their numerical inferiority in the Health Insurance Policy Deliberation Committee and majority rule of it made the Korean Medical Association

representatives take an extreme measure to oppose the decision of the Health Insurance Policy Deliberation Committee, leaving meetings before the end.

As shown above, among the three medical professions, fees for medical services in the NHI are the most important for western medicine, because they amount to over 60% of payments in the NHI. The importance of fees in the NHI has increased for western medicine since the separation system was enforced in 2000. Western medicine has an unfavourable position in the fee setting process, primarily due to the structure of the Committee and their comparatively poor strategies to increase their fees in the NHI. Western physicians believed that they did not need any preparation or strategy, because fees for medical services should be increased “naturally”. During their urgent fight against the separation system, pharmacy and the government, western medicine had put aside the issue of increasing medical fees in the NHI.

8.4 Strategy and Political Capacity of Oriental Medicine

Oriental medicine was the main medical profession that was the least influenced by the National Health Insurance. According to an interviewee (*OrientalDoctor4*), the proportion of incomes from insured oriental medical services vs. that from non-insured ones was almost 50:50. However, according to a high government official (*GovernmentMember4*), the proportion of the income from non-insured services was much higher. Nevertheless, the weight of insured services was becoming more and more important.

When I opened my clinic, the proportion of income from the NHI was very small, but now there are many oriental medical clinics, and they would have financial difficulties without NHI. ... Every year, 730 new oriental doctors enter the market (*OrientalDoctor3*).

In order to support young doctors and to make their position as a medical profession stronger, the Association of Korean Oriental Medicine has chosen a practical strategy, incorporating more oriental medical services into the National Health Insurance.

The organisation responsible for health insurance in oriental medicine appeared to have a higher position than that in any other medical associations. The Health Insurance Department had the largest budget for the project for standardisation and systematisation of oriental medicine and the largest number of personnel in the AKOM (*OrientalDoctor4*).

For the project of bringing oriental medical practice into the NHI scheme, the AKOM created a special fund. The AKOM also asked for cooperation from academic

members in oriental medical universities, who could help to standardise and systematise oriental medicine. Leaders of oriental medicine expected that the demand for oriental medicine would increase and that their professional position would become stronger, particularly if the number of oriental medical treatments covered by the National Health Insurance increased.

To be a real medical profession in Korea, patients' access to it should be easier. So, the answer is increasing the number of oriental medical services covered by the National Health Insurance. By insuring our practice, we'll increase demand for oriental medicine itself. Honestly, we have to draw patients into our oriental medicine from western medicine. Then, our pie itself will be larger. (*OrientalDoctor4*)

The preparation of the AKOM for insuring the service of prescribing and preparing oriental medicines shows what they were concerned about and how they responded to the NHI policy.

Before the government insures it, we should first develop our own specifications about the scope of medication, dosages, proper price and so on. That is why we do not actively demand that the government insure preparing oriental medicines yet. The most difficult thing is to find an optimal fee for medical services in the NHI. The fee should be low enough to expand demand and high enough to give good benefits to oriental doctors. Of course, fees are fixed by the Health Insurance Policy Deliberation Committee in the government, but we first have to find a basis and alternatives. Then we can suggest our alternative to the Health Insurance Policy Deliberation Committee. (*OrientalDoctor4*)

In the Health Insurance Policy Deliberation Committee, the oriental medical representative was a comparatively comfortable rider among the Supplier representatives. The proportion of payments for oriental medicine in the NHI is about 4% and then oriental medicine was not the target of other representatives' attacks.

One day, in a meeting of the Health Insurance Policy Deliberation Committee, I became angry and shouted. "This meeting is presided over by a Vice-minister of the Nation. What is the original purpose of this meeting? One group is arguing this and another is arguing that. We are only opposing each other. What is this?" (*OrientalDoctor4*)

The representative of oriental medicine was composed enough in the Health Insurance Policy Deliberation Committee to urge those present to remember "the original purpose of the meeting". It implied that the oriental medical interests and situations in the

National Health Insurance were not as imminent or desperate as those of western medicine in the Committee.

When it comes to the attitude of oriental medicine to other professions in the NHI, oriental doctors believed that an increase in fees for western physicians had caused financial difficulties for National Health Insurance. They argued that fees for western physicians increased “too much”. This implies that western medicine was the target in the National Health Insurance for other medical professions, as well as for the Payer Group and the Public Interest Group.

8.5 Strategy and Political Capacity of Pharmacy

When expanding the national health insurance scheme to the entire population in 1989, the government had applied its repayment system to pharmacy. Now there are five service fees for pharmacists paid by the National Health Insurance: fees for management of a pharmacy, preparation skill, administration of medicines, preparation of medicines and management of medicines. When a patient asked a pharmacy to prepare medicines according to a doctor’s prescription, the National Health Insurance Corporation paid the pharmacy, including all five items. The proportion of payments for pharmacy in the NHI is about 27%.

According to the leader responsible for health insurance in pharmacy, pharmacy has attempted to make and add other service items for coverage by the National Health Insurance, such as a fee for examining a prescription or a fee for changing a form of western medicine.

A leader of pharmacy said that their strategy with the National Health Insurance was different from that in other conflicts. Over the NHI, “pharmacy owed western medicine (Pharmacist3)”.

We just followed them [western medicine]. We only said - “We, too!” It was western medicine that fought in the foreground [in the NHI]. We only argued, “we, too!” ... But our increased rate of fees should be slightly lower than that of western medicine. Some pharmacists blamed us for it – “Those foolish guys [the leaders of pharmacy] lost again.” However, I believe that our strategy was right. It was right to obtain less in the National Health Insurance than western medicine did. We didn’t have to be a target. The press only attacked western medicine, which got the largest rate of increase. We survived in the National Health Insurance only with the ‘we-too’ strategy. I do still believe our strategy was right (Pharmacist3).

Pharmacists’ general strategy was depending on western medicine, and specific strategy was individually attacking other’s demands (GovernmentMember3).

Pharmacists' preparation and strategy to increase their own fees were fine and cautious, particularly compared with western medicine. According to a civic representative (*CivicGroupLeader3*), the pharmacists' financial papers, which estimated their loss from the separation system, were surprisingly clear and accurate, including all expenditure items. In the end, pharmacists obtained as much as they wanted, according to their paper.

The department of health insurance also took a high position in the Korean Pharmaceutical Association. However, the KPA appeared neither to focus its policy on health insurance, nor to access it as positively as oriental medicine, because increasing their fees in the NHI was not the main issue for pharmacy. The conflict with oriental medicine, the separation scheme and establishing six-year pharmaceutical colleges have been primary topics in pharmacy. Also, pharmacy did not have as strong a motive to approach the health insurance scheme as oriental medicine did. To reinforce its professional identity, pharmacy chose to develop its training system and to introduce a clinical pharmacist system. According to a leader of western medicine:

Pharmacists also concentrated on expanding the scope of over-the-counter medicines, which pharmacists could manage without doctors' prescriptions. That is why pharmacists showed less interest in increasing their NHI fees (*WesternPhysician10*).

Therefore, there appeared to be no comprehensive and particular strategy from the Korean Pharmaceutical Association to win in the struggle for the NHI.

In the Health Insurance Policy Deliberation Committee, pharmacy could evade other representatives' attack on the Supplier Group. Because the items of the fee for pharmacists in the National Health Insurance were "only" five, pharmacy was a comfortable rider supporting western medicine, whose items were over 3,200.

When it comes to pharmacists' attitudes toward other medical professions with regard to the National Health Insurance, pharmacists still criticised western physicians for taking too large a share of the National Health Insurance. In addition, pharmacists were enraged at western physicians' argument that pharmacists were paid too much for a simple and mechanical service. They responded to it by contending that pharmacists gave patients professional services with professional knowledge, as western physicians practised western medicine with their professional knowledge (*Pharmacist4*).

8.6 Role and Attitude of the Government

During the conflict between western medicine and pharmacy over the separation system in 1999 to 2001, the government increased medical fees on five occasions, before the National Health Insurance Corporation announced that it faced serious deficits. In 2001, when the Health Insurance Policy Deliberation Committee was established, the deficit of the National Health Insurance was 2.4 trillion Won [£ 1.2 billion]. Therefore, the first concern of the government with regard to the NHI was its financial stability. The government belongs to the Public Interest Group in the Health Insurance Policy Deliberation Committee.

National Health Insurance Corporation have tried to curtail the deficit so far. The collection rate of contributions is up to 99.6%. From next year, we must not meet a deficit any more. We should consider this point when we decide the monetary value per unit of medical services and the contribution rate. We should regard the financial balance of the NHI as the basic assumption of our meetings. (A comment by a representative from the government in a meeting of the Health Insurance Policy Deliberation Committee)

Therefore, in the Health Insurance Policy Deliberation Committee, the government focused their attention on cutting down fees for medical services.

The natural increase rate of reimbursement in the NHI becomes high, because of the increase in the proportion of the elderly, the increase in new health care expenditure and so on. We cannot control these inevitable increases in payments for medical professionals. So, we need a great help from medical professions. We can filter only clear unreasonable claims of payment from medical facilities. Please give us an alternative, if you have any (A representative of the Public Interest Group in a meeting of the Health Insurance Policy Deliberation Committee).

According to the Act, the entire Health Insurance Policy Deliberation Committee has the responsibility for deciding the level of fees for medical services and the contribution rate. Particularly, the system with three groups and the conflict between the Supplier Group and the Payer Group made the government, which belonged to the Public Interest Group, come to be regarded as an arbitrator in the neutral position. However, in practice, the position and the function of the government in setting fees in the NHI was more than an arbitrator or a coordinator between the two groups. The representatives participated in the Committee and the key leaders of individual associations argued that the government controlled and led the process. The analysis on the process and the results

of setting fees, particularly comparison between alternatives from individual groups⁷¹ and the decisions in the Committee showed that the government played an active role in the process of setting fees in the NHI (Choi, H., 2004: 143-144).

The representatives in the Health Insurance Policy Deliberation Committee argued that at the end the key was in the government's hands. In addition, the atmosphere in the Health Insurance Policy Deliberation Committee was filled with tension between the Supplier Group and the Payer Group, which made the government's position stronger.

Finally, we might follow the intention of the Ministry of Health and Welfare. When two players [the Supplier Group and the Payer Group] fight with each other, or even when the government encourages them to fight with each other, the government steps forward, appearing ... "OK, we will solve your problem." Some times the government is on this side and other times on that side. Then, the government can increase contributions or curtail fees for medical professionals. (*Pharmacist3*)

Within the Health Insurance Policy Deliberation Committee, every group [every representative] has its own argument. After all, the government plays a key role in deciding something. (*OrientalDoctor4*)

A high government official admitted that:

The government can recommend pro-government persons as representatives of the Public Interest Group. Then, the government can attempt to pass its plan by persuading the representatives of the Public Interest Group to agree on it. (*GovernmentMember4*)

Supplier and Payer representatives were appointed as individual associations or unions recommended. However, representatives of the Public Interest Group were recommended by the Ministry of Health and Welfare. At this point, the Minister has his/her political influence and can appoint pro-Payer figures or pro-Supplier figures as representatives of the Public Interest Group. Until then, the government choice appeared to be the former.

The study analysing alternatives from different groups and the Committee's final decision about the monetary value per unit point of medical services also shows that the decision was actually made after the government had already set its intention and purpose (Choi, H., 2004)⁷². The study shows that the government had a superior position in

⁷¹ In the Health Insurance Policy Deliberation Committee, the groups are individually required to suggest an alternative of a monetary value per unit point of medical services and of a contribution rate.

⁷² The study (Choi, H., 2004) is the first one to analyse the inside process of setting fees in the NHI since the contract system was introduced in 2000. There was no earlier study on it, mainly

accessing financial data of the NHI, which allowed it to develop more feasible alternatives. Because the Supplier Group and the Payer Group faced each other with strong tensions, the government, which had clearer and more consistent objectives than the two groups, could more easily control both groups (Choi, H., 2004).

The objective of the government in setting fees for medical services in the NHI was financial stabilisation. Therefore, the government's active function in the process of setting fees was not favourable to the Supplier Group. Given that the proportion of payment allocated to western medicine in the NHI was the highest and that they were the most discontented with the system and the results of the Committee, the government's role in the NHI was the most undesirable to western medicine among all the medical professions.

8.7 Interpretation of the Conflict

The conflict among western medicine, oriental medicine and pharmacy over the national health insurance was a hidden key issue in Korean health care. How the medical professions acted in this conflict, what kind of strategy they employed and what kind of factors influenced the conflict were examined here.

8.7.1 Claiming Jurisdiction or Own Share in the NHI

In Korea, the fact that a medical service supplied by a certain medical profession is covered by the National Health Insurance has the following meanings. Firstly, the medical profession has an exclusive jurisdiction of the medical service. Secondly, the medical profession has more economic benefits, because the demand for the service increases. Therefore, in recent years, the NHI is a new issue in which professions argue about entry of a medical service, which services are covered by NHI and whether the government approves the entry of a certain medical service into the NHI. All these have provoked conflict among medical professions. The situations of the NHI were directly and officially related to monetary interests of the medical professions. At the same time, the level of fees for medical services in the NHI was related to professional pride and position.

Behind the external professional conflicts, the NHI has been an important part of conflict or has influenced the conflict. In the conflict between western medicine and pharmacy over the separation system, increasing fees in the NHI was employed to tease medical professions. Particularly for western physicians, increasing fees in the NHI was a compensation for their loss from the separation system. In the conflict between western

because the decision had been made internally and it was hard to collect data about it.

medicine and oriental medicine over *IMS & Needle TENS*, conflict in the NHI was another jurisdictional conflict between professions to protect or expand jurisdiction.

More directly with regard to the NHI, the three main medical professions competed with each other to obtain a bigger share of the insurance fund in the Health Insurance Policy Deliberation Committee. However, in the conflict over the National Health Insurance, there was a fundamentally different situation from in the other conflicts. In the former conflicts, medical professions faced people's check and opposition, which had only a form of public opinion or, partly, civic pressure groups' opinions. In the Health Insurance Policy Deliberation Committee, those were more specifically and strongly organised in the form of the Payer Group and the Public Interest Group. The representatives of payers, which the most influential trade unions in Korea led, strongly opposed the medical professions' arguments for increasing fees. Under these circumstances, as the same suppliers of medical services, medical professions cooperated with each other to increase the contribution rate and payments for themselves. However, as the government emphasises the importance of allocating in a fair way the NHI fund to medical professions more than of increasing in an equitable manner the rate of monetary value per unit of medical services, conflictual relationships among medical professions will become stronger.

Over 60% of the payments for providers of health care in the NHI are allocated to western medicine. However, in the system of setting fees, western medicine was the weak partner, which had to follow the majority rule. Among 8 representatives of the Supplier Group, three came from western medicine, including the representative of the Korean Hospital Association. Western medicine was in the situation that it needed help from the other supplier representatives, while pharmacy and oriental medicine appeared to be carried on the back of western medicine by giving their assistance and taking their gains from the result in the NHI.

8.7.2 Environmental Factors of the Professional Relationship in the National Health Insurance

In the NHI conflict, the most influential factor was the structure of the Health Insurance Policy Deliberation Committee, which decided medical fees and contribution rates of the NHI. Because the meetings were not open, only the 24 representatives and the government officials concerned knew the full specific decision-making process and contents. Under the existing structure, the internal differentiation and dominant power among medical professions worked rather in a reverse direction, described as follows.

From a professional perspective, western medicine and oriental medicine came first and then pharmacy. Whatever influence pharmacy in Korea had in practice, their service was supplementary in health care. From a practical perspective, western medicine had dominant power in health care. In terms of its number of members, the amount of budget, and the strength of professional and political influence, western medicine had the strongest influence in Korean health care. Nevertheless, stratification and the existence of dominant power in health care did not have much influence on deciding fees for services. Neither did the dominant power of western medicine affect the Health Insurance Policy Deliberation Committee. Western medicine was one among 6 health care supplier groups in the Health Insurance Policy Deliberation Committee. According to the majority rule, western medicine never won the negotiations in setting fees in the Health Insurance Policy Deliberation Committee. They often did not appear in the meetings or left before ending a meeting to express a strong objection to a decision. This implied that the dominant power of western medicine in health care did not work in the NHI.

This situation might reflect the government's policy during the conflict over the separation system, which attempted to reform western medicine and then health care. The fact that the new system of setting fees in the NHI and the structure of the Health Insurance Policy Deliberation Committee were introduced in the middle of that conflict shows it. Therefore, the NHI policy would not be favourable to western medicine, and western medicine might still be considered a group to be reformed in the medical professional system.

Another important factor influencing conflict in the NHI was the social and political atmosphere. The Health Insurance Policy Deliberation Committee was established under the Special Act for the Financial Stability of Health Insurance. At that time, serious financial difficulties in the National Health Insurance had been one of the biggest problems in Korea. Therefore, people and politicians wanted to curtail fees as much as possible and increase the contribution rate as little as possible. In addition, public opinion showed a strong antipathy toward all medical professions. Over a decade, people were tired of the series of medical conflicts. This social and political atmosphere created a strict restriction for the Health Insurance Policy Deliberation Committee in their decision-making.

8.7.3 Claiming More Pay in Different Arenas

To take a bigger share of the National Health Insurance, individual medical professions faced each other in different arenas: the workplace, the legal system, public opinion and academia.

In the workplace, medical professionals criticised other professions' "high fees" and defended their own "low fees" from other professions' criticism. Western physicians blamed pharmacists for financial deficits in the National Health Insurance. They argued that fees for pharmacists increased too much for their "simple and non-professional services". Pharmacists argued that the government increased fees for western physicians' services too much in order to persuade them to accept the separation system. Oriental doctors tended to move off to the rear in demanding high fees in the national health insurance, since they had a larger proportion of income from non-insured services. However, oriental doctors believed that western medicine and pharmacy took too much from health insurance. Medical conflict over the national health insurance in the workplace also implied how individual professions judged others' professional knowledge and skill. However, all these opinions were informal ones. In practice, they had few chances to meet each other. These opinions were indirectly delivered to others by patients.

In the legal system, the players were limited to a few representatives from medical professions. In the Health Insurance Policy Deliberation Committee, representatives from the different medical professions attempted to increase fees for their own services. However, there was no strong conflict among them in the Committee. Representatives did not attack others directly, but only suggested different opinions in general meetings or leaked information against a certain profession to representatives of payers or public opinion. In order to increase a contribution rate, "to make the whole pie bigger", medical professions cooperated with each other. However, in this case, they had to face strong opposition from payer representatives.

With regard to public opinion, this fourth case has a point different from other Korean cases and from Abbott's cases. Ordinary people and civic pressure groups, which were regarded as the public, officially joined the legal system, the Health Insurance Policy Deliberation Committee, to decide revenues and expenditures in the NHI as representatives of the Payer Group. This was the first case in Korean health care in which the public arena was officially and influentially incorporated into the legal arena. In the Committee, the public expressed their arguments in a more organised and stronger way in terms of the Payer Group voice.

In the virtual public arena, western medicine was the main target for criticism of the increase in the contribution rate, as in the Committee. Other medical professions knew it and employed that situation to make their own share bigger. However, all medical professions were also blamed for the financial difficulties of the National Health

Insurance. When they issued news items, the press and civil pressure groups focused on an increase in the contribution rate applied to the public.

In arguing for their own share, individual professions established logical foundations through documented research and study. In the Health Insurance Policy Deliberation Committee, medical professions, the government and other representatives faced each other over who would undertake the study and whether the result of the study would be accepted or not. Because representatives in the Health Insurance Policy Deliberation Committee did not trust each other, they all needed an objective foundation from neutral study in deciding a contribution rate and fees for medical services. However, the issue was so sensitive that representatives did not trust a method of research or researchers themselves. Another example of distrust among those involved in a government policy is shown in Appendix III.

8.7.4 Conclusion

The National Health Insurance was already prompting the emergence of another conflictual issue between medical professions, that of *IMS & Needle TENS*. In this chapter, strife to obtain more share of the NHI was examined, which was hidden behind the open professional conflicts, yet still reflective of characteristics present within the medical professional system.

In the conflict over allocating the NHI fund, the medical professions met a fundamental limit: people's vague checks against them were organised and specified into the forms of the Payer Group and of the Public Interest Group in the Health Insurance Policy Deliberation Committee. The arguments and voices from these two groups were even stronger than those from "the people" in other cases. In addition, the government wanted to curtail the deficits of the NHI. Under these circumstances, the medical professions showed cooperative attitudes, rather than conflictual ones, toward each other to protect or increase their shares. However, as the government emphasises rearranging the NHI fund among the medical professions, conflictual relationships among them will be stronger than cooperative ones.

In this case, other professions have taken advantage of the dominant power of western medicine. In the Health Insurance Policy Deliberation Committee, it was mainly western medicine that was attacked by other groups. This was totally different from the general situation in Abbott's theory, where dominant power leads the circumstances. This implies that dominant power in health care, that is western medicine, is still considered a target to reform in health care. This situation is consistent with what occurred during the conflict between western medicine and pharmacy over the separation system. The fact

that the present system of setting fees for medical services in the NHI was introduced at that time goes along with a situation that is unfavourable to western medicine.

Considering this conflict among the medical professions over the NHI, along with the previous one between western medicine and oriental medicine over *IMS & Needle TENS*, the NHI will become a more important source of conflict than before. As additional new medical services are introduced and developed, medical professions will compete each other to make theirs be covered by the NHI by arguing their own professional jurisdiction. At the same time, NHI's increased importance will prompt medical professions to compete with each other in order to increase fees for their own services and for their share in the NHI fund. Conflict in and over the NHI is expected to change the previous medical professional conflicts into more academic ones, which require the more theoretical bases necessary to win a conflict.

9.1 The Korean Medical Professional System in Conflict

Based on Abbott's theory of the system of professions, this study has analysed two open conflicts and two submerged conflicts in Korean health care during the last decade. Through the conflicts, the medical professional system in Korea has changed as follows.

First of all, during each of the four medical conflicts, the influence exerted by the three individual medical professions changed. With the first conflict, oriental medicine and pharmacy developed not only their specific organisational capacity, but also their fundamental professionalism. The government guaranteed oriental medicine its long-term development and promised pharmacy the separation system and a 6-year training system in pharmaceutical colleges. Therefore, the conflict strengthened the professional and social positions of these two professions in the medical professional system.

Through the second conflict, western medicine's influence in the mainstream of the medical professional system was damaged. In spite of having held the strongest professional position in health care, they did not overcome the political and social environments that favoured reform and liberalism. However, from its strife, western medicine learned how to organise and develop its own association and strategies for facing other groups. In the mean time, pharmacy again strengthened its position in the medical professional system. Attempts by pharmacy to develop social and political networks in order to overcome its professional identity crisis resulted in situations that actually favoured pharmacy.

In the third case which involved western medicine and oriental medicine, the latter kept its ascending current of development, as prescribed by the government's plan and public commitment, emerging from its first conflict with pharmacy. In contrast, western medicine had difficulty persuading the government to accept its arguments for unification between western medicine and oriental medicine. The government still considered western medicine the one to be reformed.

In the National Health Insurance conflict, western medicine was almost used by other professions. In the Health Insurance Policy Deliberation Committee, it was western medicine that was mainly attacked by other groups. This implies that western medicine, the dominant power in health care, continued to be considered a target of reform.

As shown above, through the medical conflicts, pharmacy kept and even strengthened its position in the professional system. Oriental medicine also found opportunities to develop its professionalism and fortify its position in health care. In contrast, western medicine faced its weakening influence in the medical professional

system. While experiencing these conflicts, the individual professions developed their own internal capacities, such as organisational and managerial strategies.

In addition to a change in the influence of individual medical professions, the features of the conflicts have changed. The former two open conflicts were undertaken in a strong and violent way, using strikes and street demonstrations. However, in the latter two conflicts, medical professions attempted academic and logical strategies to control their situations. Although the latter conflicts are still submerged, seldom in the past had there been such an attempt by medical professions to look for academic bases for their own arguments.

Another important point is that the National Health Insurance will be a more important conflictual issue or arena in the future, as demonstrated in the latter two cases. As more new medical services are introduced and developed, medical professions, mainly western medicine and oriental medicine, will compete their own professional jurisdiction with each other in order to assure their services are covered by the NHI. At the same time, the medical professions will more keenly compete each other to increase their own shares in the NHI.

More specific reasons and factors inherent in the four medical conflicts are presented below. Those are specifically compared with Abbott's work.

9.1.1 Jurisdictional Conflict for Professional, Economic and Political Reasons

Through the four medical conflicts, more complex causes and situations have been uncovered in the medical professional system and health care in Korea than those in Abbott's (1988) theory. The conflicts have developed from professional jurisdictional ones into economic and political ones.

All of the conflictual cases in this study show that they had characteristics of jurisdictional conflict, as Abbott (1988) suggests. The conflict between oriental medicine and pharmacy was one over preparing and selling herbal medicine. The second one between western medicine and pharmacy was over preparing and selling medicines and over prescribing medicines. Western medicine and oriental medicine were in conflict over *IMS & Needle TENS* and more fundamentally over unification of the two medicines. As in the case of *IMS & Needle TENS*, covering an item of medical services by the NHI was related to a guarantee that the item would be the jurisdiction of a particular profession.

However, in the Korean cases, jurisdictional conflict developed into more complicated and dynamic ones than those identified in Abbott's analysis. The conflict over the separation system requires Abbott's concept of jurisdiction to be more refined

and specific, including jurisdiction with two dimensions, the scope or arena of work and the degree of possession of the field. In addition, the conflict between western medicine and oriental medicine shows that there are two different levels of jurisdictional conflict existing at the same time. While oriental medicine focused on the practical issue of *IMS & Needle TENS*, western medicine attempted to address a more fundamental issue, unification of western medicine and oriental medicine. With different dimensions and levels of jurisdictional conflict, the Korean cases show how professional conflict can change into more complex forms.

The jurisdictional conflict in Korean health care basically reflects different professional knowledge, logic and legitimacy of the individual professions. Therefore, in every conflict, the professions involved considered it a matter of professional identity and pride, not only a specific professional jurisdiction or right.

The economic motive in medical conflict is one of the most outstanding points of the Korean cases, which Abbott (1988) hardly mentions. Behind every conflict, there was monetary interest, which mainly came from contextual reasons, as Latham (2001) and Rodwin (1993) have suggested. Over 90% of medical facilities had been established by individual medical professionals and private organisations. The government had few plans or policies about the professional personnel in health care, which caused a rapid increase in the number of medical professionals. Under these circumstances, managing their own medical facilities and making a profit were among the most important purposes for medical professionals.

The economic factor was most outstanding in the conflict between western medicine and pharmacy. The most controversial jurisdiction in the conflict, the right to prepare medicines, had another important meaning, which was the right to access *margins*, the illicit income from pharmaceutical companies. This conflictual case revealed a more influential circumstance in which fees for medical services in the National Health Insurance were even lower than cost. Then, *margins* had functioned in compensating western physicians for low returns in the NHI.

In addition to the contextual reasons, medical professionals had an individual motivation for monetary benefits. As professionals in health care, they expected 'fair pay' consistent with their professional work and position. Monetary interests of professions combined with their professional pride to create a stronger conflict.

In the meantime, in order to protect and increase their share of the NHI, medical professions have shown evidence of relationships that are more strongly cooperative than conflictual when facing their common counterpart, the Payer Group. This situation could be further evidence of how important economic interests are for medical professions.

The conflict over the separation system developed into a political and ideological one. Before it began, western physicians had been inclined to be conservative, but not in an outstanding way. When the reformists enforced the separation system, that vague political inclination to conservatism existing in western medicine rapidly turned into a clear one. The separation scheme was the trigger for a political and ideological collision between the two professions. The Presidential Election of Korea in 2002 reflected exactly the different ideological inclinations of the professions: western physicians' disposition toward the free market system and against socialism or communism vs. pharmacists' leaning toward liberalism.

In the case of setting fees for medical services in the National Health Insurance, different political inclinations appeared between the groups who participated in the process. Against western medicine, the most important medical profession in the Supplier Group, the representatives of trade unions within the Payer Group showed the strongest reaction. This implied that conservatism and liberalism between the two groups would collide with each other again in the National Health Insurance.

9.1.2 Environmental Factors of the Conflicts

Abbott (1988) suggests diverse internal, social and cultural environmental factors which influence professional conflict and a professional system. Applying Abbott's factors to the Korean cases, the following points stand out: organisational development of individual professions; inconsistency between the influence of a dominant profession and the actual result of conflict; more dynamic and fundamental influences of political, economic, social and cultural factors; and the influence of the government's mismanagement.

9.1.2.1 Organisational Development

More specific and dynamic organisational development than Abbott (1988) mentioned was found in every medical profession during conflict in the Korean cases. The first conflict for each profession caused a change of their leadership, a shift in generations and an emergence of reformists within the leading group. In the medical conflicts of the last decade, *the so-called 386 Generation* played an important role in leading an association and collective actions in every medical profession.

With the conflict, the professions also developed their managerial capacity. They established and employed the internet communication network. Through conflict, professions developed their own strategies and tactics for collective actions. They also attempted to look for academic and rational foundations for their arguments, instead of resorting to radical physical collective reactions. Autonomy and mobility from diverse

and voluntary sub-groups in individual associations also increased. The Meeting for Saving Small Clinics, the Democratic Physician Society and the Meeting for Saving Local Pharmacies are good examples. They actively engaged with the process of decision-making in their associations and worked through the internet and in practice to influence the situations.

In addition, the conflict developed political capacity among the professions concerned. The medical professions learned more about how to contact and persuade other groups, such as the government, the political field and civic pressure groups. They attempted to find and mobilise all networks and lines that they could.

9.1.2.2 Other Internal Factors

As an important internal factor, Abbott suggests dominant power in a professional system (1988: 135-138). The Korean cases show that dominant power in the professional system in health care does not correspond to the result of conflict, because even dominant professions could not make conflictual situations favourable to them.

Oriental medicine is superior to pharmacy in professional role and position. However, it is difficult to say that pharmacy lost the conflict. While western medicine is a dominant power in health care, it was damaged during the conflict over the separation system. Compared to oriental medicine, western medicine still has a superior status and prestige, but the situation has not been advantageous for western medicine in the conflict between the two professions. In spite of the professional position of western medicine in health care, they are weak in the National Health Insurance scheme.

All these incongruent situations firstly come from the existing social and political situations: reformists in the political field and then in health care came into power and intended to reform Korean health care mainly by reforming western medicine. This implies conflict between an existing dominant power, that is, western medicine, and reformists in health care. Then, in the last decade, the latter has benefited. The dominant power, or a superior group, has failed to persuade or control the government in individual conflicts and western medicine has particularly been a target of reform.

In contrast to the western cases mentioned by Abbott (1988), in the Korean cases internal competition and stratification of a profession was a driving force against an opposing profession during a conflict. The relationship between trainee doctors and specialists in western medicine is a good example. Young trainee doctors rose up against the separation system and led the *war* against pharmacy and the government. Instead of internal conflict between specialists and trainee doctors, western physicians chose an external conflict with other professions. The strict hierarchy between seniors and juniors

and strong solidarity among members did not allow any resistance *within* the profession. Pharmacy and oriental medicine also preferred external conflict with other professions to internal conflict among their own members.

9.1.2.3 Social and Cultural Factors

As presented in Chapter 2, Introduction to Korean Health Care, professional consciousness based on professional knowledge, financial pressure in health care, social movements and political trends toward reform or liberalism were influential factors in the Korean medical conflicts. Abbott suggests specific social and cultural factors which change the medical system, such as technology, bureaucratisation, internal division of labour, professional knowledge and moral foundations. In the Korean cases, however, more fundamental and comprehensive contexts caused conflicts between medical professions and influenced the medical professional system.

In every case involving oriental medicine, the arguments for modern scientisation and a traditional approach to medicine collided with each other. This controversy initially started from the perspective of professional knowledge and technology. Soon, it developed into a conflict about a different consciousness or ideology, such as traditionalism or nationalism vs. western scientisation or modernisation. In Korea, traditionalism has appealed to the public.

Whenever pharmacy has been involved, the pharmacists' attempts to keep their social and professional position, which had been as high as other main medical professions, have collided with other professions' existing jurisdictions. Whenever western medicine has appeared as a player in conflicts, social and political conflict between liberalism and conservatism has followed. Western physicians have had to face groups and social atmospheres toward liberalism in every case of conflict.

Particularly, the international tendency of medicine toward the emergence of alternative medicine, combined with international pressure to open the domestic medical market, provide yet another issue to influence the medical system.

In all cases, financial pressure from the rapid increase in the number of medical professionals has pushed conflict to greater intensity.

9.1.2.4 Factors from Mismanagement of Health Care Policy

Differently from Abbott's cases in western countries, mismanagement of health care policy and policy failure has caused conflict between and among medical professions in Korea. The following three points concern the influence of health care policy.

First of all, the government's late attempt to enforce a policy, which had been stipulated but ignored only to remain unenforced, caused conflict in health care. When the government began to enforce a system *in principle*, the professions concerned, which had been accustomed to the existing practical customs, showed a strong resistance. The separation system is a representative example. In 1963, the separation system was stipulated, but remained unenforced until 2000. For over 35 years, with the provision of separating prescription and preparation of medicines not being applied in practice, the government, western medicine and pharmacy had managed to continue according to established and convenient practices. With the attempt to enforce the separation system, a huge objection and resistance was started by the medical professions.

The levels of fees for medical services in the NHI and the contribution rate of the NHI is another example. The government as well as medical professions had realised that the two levels should increase in order to operate the NHI properly. However, in order to obtain public support, particularly for the military governments, the government had kept low levels of fees and contribution rates of the NHI, employing *margins* from pharmaceutical companies to compensate for the gap. When the government attempted to eradicate *margins* through the separation system, the biggest conflict in Korean health care started. Government attempts to increase the levels of fees and contribution rates in the NHI led to serious financial deficits and resistance from the Payer Group.

Another cause of conflict in health care from government's negligence was the government's personnel mismanagement in medical professions. The number of medical professional universities, their quota for new students and the resulting new medical professionals rapidly increased without the government's control and long-term personnel plan. These situations provoked serious competition and then conflict among medical professions.

Secondly, in the Korean cases, a policy triggered a conflict and then its settlement became the cause of the next conflict. Enforcing the separation system and lengthening the training course for pharmacists were important terms used to settle the first conflict between oriental medicine and pharmacy. However, each requirement caused other conflicts. One was conflict between western medicine and pharmacy over the separation system and another was resistance from two other professions against the training system plan of pharmacy. Another example was found in the NHI. To settle the conflict between western medicine and pharmacy, the government increased fees for medical services in the NHI, but when the National Health Insurance Corporation publicised the NHI deficit and decreased the fees in the NHI, conflict in the NHI started.

Thirdly, the newly imported western systems and health care policies collided

with each other and with existing traditional ones in Korean health care. A social health insurance scheme introduced mainly from Japan started to conflict with the free competitive market system of medical services, as the scope of the insurance expanded to the entire population. Specialisation and division of functions in western medicine collided with holism in oriental medicine. Western physicians and pharmacists do not believe in the holistic practice of oriental medicine. Considerable numbers of oriental doctors are still sceptical of practice in western medicine. Introducing the speciality system to oriental medicine and creating the new profession of oriental pharmacy, both of which came from western medicine, have caused internal conflict even within oriental medicine between those supporting a newly modernised practise and those retaining a traditional approach to medicine. Alternative medicine introduced mainly from the US also provoked a conflict between western medicine and oriental medicine.

The UK, US, France or Germany often taken in Abbott's work as examples, have tended to develop their health care system in their own ways over long periods. In contrast, importing and translating a system or a policy from developed countries was an essential factor in developing Korean health care particularly in a short period. During the process, conflict between the newly imported systems and the existing ones was inevitable.

9.1.3 Who Regulated Conflict?

Abbott suggests three arenas where professions claim their sole jurisdiction. Beneath his argument, he assumes that claiming jurisdiction occurs first in the workplace and situations in the public arena influence and link to the legal arena. Based on this process, Abbott has explained that public audience or the government regulate conflict in western countries.

However, Abbott's logic and explanations are not exactly consistent with the Korean cases. Most of all, in the Korean cases, the main fields where claiming sole jurisdiction and conflict occurred were the public and the legal arena. In the workplace, there were few cases in which the three medical professions directly faced each other, although they had competed with each other to attract patients. The exceptional case was the relationship between western medicine and pharmacy, after the separation system.

In addition, the arenas and the players in those arenas were not consistent with those in Abbott's work. In the Korean cases, civic pressure groups and the press played important roles in creating public opinion in the public arena, which is compatible with Abbott's explanation. However, civic pressure groups played an active and official role in the legal arena, as did the political system at the higher level and the administrative

system at the operational level. They would suggest alternative settlements, which were often chosen instead of the government's. Civic groups had been important supporters for the liberal government, which is why they could join the decision-making so actively. Therefore, in the Korean cases, where a player functioned, as well as who regulated a conflict, should be examined.

In the first case of conflict between oriental medicine and pharmacy, it is difficult to assess who mainly controlled the system. Public opinion favourable to oriental medicine might influence the higher political field. At the operational level of the government, specific regulations were set in favourable of pharmacy to settle the conflict. While oriental medicine developed a refined and well-organised lobbying process to persuade the political and administrative system, pharmacy had its colleagues, ex-pharmacists and government officials, within the government, who were well informed about the whole process in the political and administrative system.

In the legal arena, civic pressure groups as well as the government were important players as arbitrators. A civic group would suggest an alternative to settle the conflict, and it was eventually accepted by the professions and the government. The government had difficulties controlling the situations, which is why a civic group were involved in the conflict as an arbitrator. Nevertheless, the government still played an active role in the conflict. Near the final stage, negotiations were undergone individually between the government and pharmacy and between the government and oriental medicine.

In the second case of conflict over the separation system, public opinion and the press led criticism against western medicine. Civic pressure groups attempted to function as arbitrators between the two conflictual professions in the beginning and helped them reach their first agreement. However, they then changed their role into an attacker of western medicine, as western physicians started to resist the separation system. The top political field in the government was actively involved in the whole process of enforcing the separation system. At the time, the liberal party took power and attempted to reform health care. As resistance from western medicine became stronger, the main controllers changed from the ministerial field of the government, through civic pressure groups, into the political field. However, in setting specific regulations and systems, the administrative part of the government continuously functioned as the influential player by preparing for and specifying the separation system.

There has been strong criticism of the government's role in the second conflict, because it failed to manage the disorder and its reactions and policies were not consistent. Nevertheless, the government was in the centre of the conflict from the beginning to the

end as the starter, arbitrator and settler. The later part of the conflict was actually between western medicine and the government, not western medicine and pharmacy.

In the third case of conflict between western medicine and oriental medicine, the government controlled the situation by showing a stronger and more consistent role than in any other cases. The position of the government on the issue of unification was clear. The government declared that the two different medicines would exist independently and announced schemes to develop oriental medicine. Therefore, in the legal and administrative arena, oriental medicine had an advantage. In the arena of public opinion, the issue did not stand out clearly, because the conflict was only in the early stage.

A feature of this conflict that was totally different from the former two was that it was an academic one. As those concerned were collecting academic foundations for their arguments, academia emerged as a new and important arena where the two professions collided with each other.

The fourth case has a point different from other Korean cases and Abbott's cases with regard to the public arena. Here the public arena was officially incorporated into the legal arena. Civic pressure groups and other civilian groups participated in the Health Insurance Policy Deliberation Committee as representatives of the Payer Group, and expressed their arguments in a stronger and better-organised way in the NHI. In the *virtual* public arena, as in the Committee, western medicine was the main target for criticism of the increase in the contribution rate.

In the legal system of setting fees for medical services, the structure of the Health Insurance Policy Deliberation Committee and majority rule in the Committee were the most important factors in the decision-making process of the NHI. Decision-making about the NHI was almost entirely in the government's hands. The government had a superior position for accessing financial data of the NHI and developing more feasible alternatives. While the Supplier Group and the Payer Group opposing each other, the government, which had clearer and more consistent objectives than the two groups, could more easily control both of them. The objective of the government in setting fees for medical services in the NHI was financial stabilisation. Therefore, the government's active function in the process of setting fees was not favourable to the Supplier Group, particularly to western medicine.

The academic arena emerged as important in the NHI, as it had in the conflict over *IMS & Needle TENS* and unification. In arguing for their own share in the NHI, individual professions needed logical foundations, and documentation required research and study.

The four Korean cases show how actively all the actors concerned participated in the conflicts. Through the conflicts, all the players - not only the professions involved but also civic groups and others - learned how to react and manage situations and to develop their own organisations and strategies.

9.2 Theoretical Implications

9.2.1 Professional Theories in Relation to the Korean Case

This study mainly employed Abbott's work to explain the Korean cases and examine whether his theoretical framework is applicable. The analysis of the study presents Abbott's theory as useful in explaining the recent medical conflicts in Korean health care from the perspective of a system that considers complicated and diverse factors. However, there are also limitations to Abbott's work in explaining the Korean case. This study has the following theoretical challenges and implications.

First, the discussion about the other three Asian cases implies that Abbott's theory is more useful for explaining the Korean case than the Chinese, Indian or Japanese one. While the medical professional systems in those countries have mainly been influenced by the states' goals and political decisions, the recent professional conflicts in Korean health care have also witnessed active reactions and strategies of the medical professions concerned - dynamic relationships between them and other influential factors, and not only the influence of the government. In Abbott's work, all those factors are considered together without attributing different weights to them, which seems applicable to the Korean case.

However, Abbott's theory has limitations for the Korean case. Particularly in discussing the following two points, alternative theories were needed: the professions' economic motivation and the role of the state.

While Abbott (1988) hardly mentioned monetary interests in his work, the economic motivation in medical conflict is a salient factor in the Korean case. Behind every conflict, there was monetary interest. It was particularly outstanding in the conflict between western medicine and pharmacy as compared with other cases, because of the *margins*.

The medical professions' pursuit of income in Korea arose mainly from contextual reasons, as Latham (2001) and Rodwin (1993) have suggested. Over 90% of medical facilities had been established by individual medical professionals and private organisations. The government had few plans or policies concerning the professional personnel in health care, which caused a rapid increase in the number of medical professionals. Under these circumstances, managing their own medical facilities and

making a profit were among the most important purposes for medical professionals.

Along with these contextual reasons, medical professionals had an individual motivation for monetary benefits. As professionals in health care, they expected 'fair pay' consistent with their professional work and position. Monetary interests of professions combined with their professional pride to create a stronger conflict. The medical professions' monetary motivation in the Korean case appears to be consistent with Larson's argument that the important feature of professionalisation is a profession's attempt to improve its economic position and then secure its monopoly in the market.

In addition to an inadequate discussion of the economic motivation, Abbott also accords insufficient importance to the role of the state, identifying it as only an environmental factor in the system of professions. In the Korean case, however, the government has functioned as more than an audience or purely mechanical agent, as suggested by Abbott. In each of the conflicts considered in this study, the government started from a position with an intention to favour or control one of the medical professions. As a conflict developed with other pressures from professions themselves and external forces, the government had to change its original purpose into more compromised one. Nevertheless, the government was more influential than any other environmental factors either in forming an outline of health care policy or in specifying regulations.

Monopolists, particularly Larson have emphasised the state's role in professionalisation. The Korean government played an active interventionist role when introducing important health care schemes, such as the National Health Insurance and the separation system. From that perspective, the concept of an interventionist government could be relevant. However, Larson's model cannot exactly explain the Korean case. The reason is that it is difficult to argue the Korean government attempted to protect a certain medical profession with the intention of granting it monopoly in the market. Instead, the present liberal government has attempted to break the monopoly of western medicine in the three most recent cases. Therefore, Larson's explanation of the state's role, which sees it as intentions to guarantee a profession's monopoly, would not be consistent with the Korean situation. This also implies that there is a limitation to applying the monopolist professional theory to the recent medical conflicts in Korean health care, although their fundamental viewpoint, which considers the government's function more important than does Abbott, is closer than Abbott's to the Korean case.

9.2.2 Abbott's Theory for the Korean Case

The results of the analysis suggest that there were more implications than those identified

by Abbott. The following shows how difficult it is for the Korean cases to be explained only by Abbott's work, since they were very dynamic and complicated.

Firstly, the Korean cases require Abbott's concept of jurisdiction to be more specific. Regarding the separation system conflict, jurisdiction had two dimensions, which were the scope or arena of work and the degree of possession of the field. Over prescribing and preparing medicines, two professions played opposite roles at the same time as both attackers and defenders. In addition, the conflict between western medicine and oriental medicine showed that there are two different levels of jurisdictional conflict existing at the same time. While oriental medicine focused on the practical issue of *IMS & Needle TENS*, western medicine attempted to develop the more fundamental issue of unifying western medicine and oriental medicine. With different dimensions and levels of jurisdictional conflict, the Korean cases show how professional conflict can change into more complex forms.

Secondly, all the conflictual cases in Korean health care presented in this study show that they had characteristics of jurisdictional conflict as Abbott (1988) has suggested. However, the Korean cases incorporated not only professional characteristics of conflict but also economic and political ones. In every conflict, the professions involved considered the issue a matter of professional identity and pride, not only disagreement about a specific jurisdiction. The professions' economic motivation was a salient factor in the Korean case. The conflicts were also political battles. The conflict over the separation system marked a turning point in which western medicine and pharmacy revealed their different political or ideological inclinations of conservatism and liberalism.

Thirdly, as an internal factor, more specific and dynamic organisational development was found in every Korean medical profession than in the cases Abbott (1988) referred to. With the conflict, professions also developed their managerial and political capacities to contact and persuade the government and other groups. The Korean cases show that being a dominant power in the professional system of health care does not always mean conflictual issues are resolved in its favour. These incongruent situations mainly came from the situation that the existing power has faced reformists in the political field and then in health care, who have benefited in the last decade and during the recent medical conflicts. Different again from western cases described by Abbott (1988), during a conflict internal competition and stratification of a profession became a driving force in the Korean cases against an opposing profession. The relationship between trainee doctors and specialists in western medicine is a good example.

Fourth, as social and cultural factors, professional consciousness based on

professional knowledge, financial pressure in health care, social movements and political situations toward reform or liberalism were influential factors in the Korean medical conflict. In every case that involved oriental medicine, the arguments for modern scientisation and traditional approach to medicine collided with each other. Whenever pharmacy was involved, the pharmacists' attempts to keep their social and professional position, which had been as high as other main medical professions, collided with other professions' existing jurisdictions. Whenever western medicine appeared in conflicts, social and political conflict between liberalism and conservatism followed. Western physicians had to face groups and social atmospheres toward liberalism in every case of conflict.

Fifth, completely different from Abbott's cases in western countries, mismanagement of health care policy and policy failure caused conflict among medical professions in Korea. The government's late attempt to enforce a policy, which had been stipulated but ignored only to remain unenforced, caused conflict in health care. One policy triggered a conflict, and its settlement caused the next conflict. Newly imported western systems and health care policies collided with each other and with existing traditional ones in Korean health care. Differently from western developed countries, importing and translating a system or a policy from developed countries was an essential factor in development of Korean health care. Conflicts between the newly imported systems and the existing ones are inevitable.

Sixth, in the Korean cases, the main fields, where claiming sole jurisdiction and conflict occurred were the public and legal arenas. In the conflict between western medicine and oriental medicine and in the conflict among the medical professions over the NHI, both of which were not open, the academic arena emerged as another battlefield between and among medical professions. In each conflict, public opinion was generally on one side, which gave pressure to the political field. However, public support was not always consistent with results in the legal arena, where the key was knowing who could better persuade the operational level of the government, namely, the government officials responsible for an issue concerned. The role of civic pressure groups emerged as important in the medical conflicts, because they functioned as arbitrators in the legal arena and as attackers of a certain medical profession and opinion leaders in the public arena. For the first two open conflicts, the government failed to control the conflictual situations and allowed other groups such as civic groups or the top political field to intervene in the situations. Nevertheless, government officials at the operational level still played important roles and influenced the settlements of the conflict in terms of setting specific regulations. For the last two submerged conflicts, the government was

still controlling the situations.

Seventh, different from existing works on professional conflict in Korean health care, this study has included a submerged conflict between western medicine and oriental medicine and a newly emerging conflict among the three medical professions in relation to the National Health Insurance. This enables the study to explore the professional system in Korean health care from a macro and wide perspective. The study also has comprehensively examined diverse environmental factors which influence both the medical conflicts and the medical professional system. This supplies more active and dynamic information, which existing studies have missed. Existing studies argue that medical disputes have caused a change in the structural power distribution among groups involved in them (Cho, 2000). In addition to that point, this study shows how social and political circumstances actually caused the medical conflicts and then influenced the medical professional system.

9.3 Methodological Implications

This study used primary data gathered by interviewing members, particularly key persons, of the three medical professions, the government, the press and civic groups. This would be the first study attempting to interview decision-makers of opposing positions at the same time about recent sensitive issues in health care. The data from in-depth and elite interviews supplied active and dynamic information about the decision-making processes in the medical professions and in the government, which before had not been covered. Statements from government officials and key leaders of medical professions reveal how the individual professions have set up their strategies and mobilised their members in the conflicts, how they have responded to and influenced others' decisions, and how the government has attempted to manage the conflictual situations. In particular, how individual professions contact and then persuade the centre of the government and the political field and how medical professions have interacted with each other in the NHI are outstanding items of information that this study collected with elite interviews.

Research using interviews has another particular meaning in the Korean academia of public or social policy, where quantitative methods have preferred. In-depth interviewing as a way of researching medical professions and their system can enrich the methodology of public policy, as well as supply further and hidden information. This study incorporated the whole process of developing the topics, selecting interviewees with the pilot survey and preparing for the fieldwork. In addition, how the interviewees were contacted and arranged, how the fieldwork took place and what outcomes were achieved and how data was analysed were presented.

Reflecting on the fieldwork, the following points are remarkable. These are expected to be lessons for elite interviews in Korea. Firstly, conflictual situations in Korean health care favoured the fieldwork, because individual professions competed with each other to appeal and justify their own situations. Secondly, when compared with those in the other medical professions, contacting and arranging to meet key leaders in western medicine was difficult. However, once accepted as a reliable researcher by them, they actively responded during interviews. Interviewing incumbent government officials was also difficult, because they had a closed attitude toward an outside person and were more cautious than other elites. Thirdly, after interviewing a key leader in a given profession and securing his trust in the research, I was able to easily contact other important persons, even in an opposition group. Preparation for the interviews, such as the supervisors' reference, and personal competency are effective in elite interview in Korea.

Employing Abbott's theory of the professional system for the study supplied a systematic and in-depth perspective for understanding the Korean case, because it considers external environmental factors, as well as the internal forces, of the system. In particular, the sociological approach highlights informal, but important, real points in the medical conflicts, which the political or public policy perspective is likely to miss.

9.4 Future Research Opportunities

This thesis attempted to examine and analyse the medical professional system in Korea from the system perspective, considering diverse and comprehensive factors based on Abbott's work. The study is expected to contribute to understanding and developing the whole medical professional system. However, it has the following limits, which mainly come from that approach.

Most of all, the research did not examine individual environmental factors in detail and in depth. Abbott (1988) suggested diverse internal, social and cultural factors, which could influence jurisdictional conflict. The Korean cases required more factors than he identified. It was difficult to specifically discuss all the related ones in one study.

There was imbalance in dealing with the four cases. The study gave more effort to the second case, the conflict between western medicine and pharmacy over the separation system, than to any others. Interviewees also spent more time commenting on that case than in the others. This imbalance might appear biased to a certain profession. However, it suggests that the case was the biggest and most important one among all the medical conflicts. Another reason for imbalance came from the fact that there were more difficulties in clearly discussing the latter two cases than in discussing the former two cases. This is because that the latter ones are still submerged, while the former ones were

open.

Those limits of the thesis are expected to give other opportunities to study in the future. Firstly, diverse factors involved in the Korean cases can be individual topics for study. The gender issue in medical professions, medical professionals' social or organisational consciousness or opening health care market will be important impact on medical professions and then the system of medical professions. More studies will be needed to prepare for the situation.

Secondly, the latter two submerged conflicts have many opportunities to be studied in the future. The relationship between western medicine and oriental medicine will be more competitive. The conflict among medical professions in the NHI will be stronger. These two cases will be main topics in Korean health care in the future, attracting much attention and requiring considerable study in the future.

Thirdly, by using in-depth elite interviews, the study led to obtaining further and inside information. More studies using a qualitative approach will be useful to understand more about medical professions and the medical professional system.

In order to understand the professional system in Korean health care, either in the academic field or in the government, those issues will/can be analysed in further studies.

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APPENDIX I. Hours of the Interviews

	Nr. of Persons	Nr. of Occasions	Total Hours	Mean Hours
Total	36	39	58h 20min (3500 min)	1h 31min
Western Physicians	14	14	22h 20min	1h 36min
Oriental Doctors	5	7	12h 20min	1h 46min
Pharmacists	5	6	8h	1h 20min
Government Officials	4	4	4h 40min	1h 10min
Civil Group Leaders	4	4	7h	1h 45min
Hospital Managers	2	2	2h	1h
Journalists	2	2	2h 30min	1h 15min

APPENDIX II. Regions & Places for Interviews

	Occasions (Persons)	Places (occasions)			Region (persons)		
		Office ¹	Restaurant	Coffee Shop	Seoul ²	Other Big City	Small City
Total	39 (36)	22	12	5	26	7	3
Western Physicians	14	9	4	1	10	4	-
Oriental Doctors	7 (5)	4	2	1	4	1	-
Pharmacists	6 (5)	3	3	-	2	1	2
Government Officials	4	1	2	1	4	-	-
Civil Group Leaders	4	2	1	1	4	-	-
Hospital Managers	2	2	-	-	-	1	1
Journalists	2	1	-	1	2	-	-

¹ Including meeting rooms

² Including satellite cities of Seoul

APPENDIX III. Case: Distrust in a Policy-making Process

A sensitive policy issue quite often makes those involved seriously distrust each other. The following anecdote from a source shows an example of this. There was a policy-making committee composed of representatives from different interest groups. Every meeting of this Committee was ‘a fierce battle’ among those present. Only the government should have had full minutes of the meetings, containing records of who said what, ‘without missing a sound of breathing’. However, as distrust prevailed throughout the representatives, a few of them started recording meetings with their concealed recorders and keeping their own minutes. At last, the government banned representatives from privately recording, searching them for concealed recorders before meetings.